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UNIVERSITY OF ALBERTA

COLLABORATION BETWEEN TRADITIONAL HEALERS AND BIOMEDICAL PRACTITIONERS: A PRAGMATIC STRATEGY

by

Nancy Gibson ©

A thesis submitted to the Faculty of Graduate Studies
and Research in partial fulfilment of the
requirements for the degree of Doctor of Philosophy

Department of Anthropology

Edmonton, Alberta

Fall 1995

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Collaboration between Traditional Healers and Biomedical Practitioners: a Pragmatic Strategy submitted by Nancy Gibson in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

Study of the potential for collaboration between biomedicine and traditional healers in Sierra Leone, West Africa, indicates that institutional-level collaboration from the perspective of a healers' association is more problematic than the *de facto* interpersonal, or microlevel collaboration. Examination of a related issue, that of ownership of indigenous healing knowledge in Sierra Leone, reveals that the concept of appropriation is not relevant to this essentially non-literate, economically stressed society. The traditional healers are not concerned with protection as much as perpetuation and transmission of their knowledge, and commercialisation of some preparations is a strategy to achieve this end, as well as an economic strategy.

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CHAPTER I

COLLABORATION: THEORETICAL FRAMEWORK AND STRATEGIES

Introduction: Defining the Problem

Collaboration between traditional healing systems and biomedical systems in third world nations has been put forward by the World Health Organisation (1978a and b) and others as a potential strategy for low cost extension of the health care system. This thesis addresses the implications of strategies for collaboration between traditional healers and biomedical practitioners regarding the ownership and perpetuation of indigenous healing knowledge in Sierra Leone, West Africa. The research employs anthropological methods and perspectives to describe and analyse the potential for collaboration on both the macro- and microlevels (DeWalt and Pelto 1985). Strategies for perpetuation of indigenous knowledge are examined within the contexts of forty-eight individual healers and a voluntary association of healers in Freetown, the capital city. Collaboration among the healing professions is submitted as an equalising strategy in a culture where indigenous knowledge has become a potential resource (Posey 1990).

The human rights movement has turned a spotlight on the political rights of indigenous people. This has brought the issue of ownership of traditional knowledge into focus, consolidating its ideological linkage with minority cultures lacking political and economic power. This perspective has fostered a tendency to venerate indigenous knowledge, creating artificial monoliths such as "traditional healing knowledge", and placing them on an ideological pedestal protected from the risk of appropriation. This icon attitude complements the desire of some indigenous people to preserve and protect their unique knowledge from applications which they consider to be inappropriate. Identification of indigenous knowledge as a political tool is often integral to revitalisation movements such as those in North America (Hoare et al 1993).

There is no comparable revitalisation movement in Sierra Leone. Despite the imposition of different values and patterns during the British colonial period the indigenous heritage remains integrated into the fabric of society. The perceptions of threat and appropriation of indigenous healing knowledge that exist in Canada (Young 1989) and elsewhere is not evident in Sierra Leone.

I will argue that the economic conditions in Sierra Leone explain this difference. The living conditions for the people of Sierra Leone are extreme. The United Nations Human Development Index for 1991 placed Canada at the top, and Sierra Leone at the bottom of the scale for quality of life (UNDP 1994). Sierra Leone is a country with chronic civil strife following on two decades of economic stagnation and the imposition of International Monetary Fund (I.M.F.) structural adjustment policies (Epprecht 1994). Everything, including traditional medical knowledge, is a potential resource.

Indigenous knowledge is generally perceived by academics to belong to less powerful social groups, often the economically, politically and socially disadvantaged. In Sierra Leone there are tribal and ethnic distinctions, but all groups consider themselves indigenous, including the Krio people, many of whom trace their descent from the freed slaves of the last century. Indigenous knowledge is not a political issue *per se* in Sierra Leone.

The word appropriation has strongly negative connotations, particularly for anthropologists, many of whom are currently engaged in preventing the appropriation of indigenous knowledge. One definition of appropriation is: "to take possession of; to take to oneself, especially without authority" (The Concise Oxford Dictionary 1982). For purposes of this study appropriation is defined as extracting indigenous knowledge and applying it outside the culture from which it originates without the participation or permission of the appropriate owners and gatekeepers. This definition suggests that the academic study of indigenous knowledge is in itself appropriation. There is an additional element in Lenore Keeshig-Tobias's discussion, that appropriation is "harmful to innocent people" (1994:1181). I would add one more component to my definition, and that is that appropriation has occurred only if a group feels a sense of loss. In this context academic exploration of indigenous knowledge may be vindicated (Ryan and Robinson 1990). The collection and dissemination of knowledge and its preservation for future generations, including future generations of the indigenous culture from which the knowledge was drawn is sufficient justification for action by outsiders. By the same token, commercialisation of products emanating from indigenous knowledge and expertise is not appropriation if no one feels a sense of loss.

Appropriation is, therefore, not a universal concern for all indigenous people. Preservation of indigenous knowledge, however, is a focus for academics and indigenous people alike. I discovered that the practical aspect of preservation of indigenous knowledge is perpetuation. Where *preservation* implies a static state--with knowledge collected and frozen in that state in files and archives, *perpetuation* implies a dynamic state. Transmission of knowledge becomes a strategy for preservation. The connotations of perpetuation are fluid, incorporating the reality of constant flux, with "...power and conflict, contradiction and opposition [becoming] part of the perspective" (Barrett 1984a:239). In essentially nonliterate societies perpetuation is the key concern. Similarly generation of marketable products at the local level derived from indigenous healing knowledge is also a strategy for preservation of that knowledge. Development of such products is a primary incentive for collaboration for both biomedical and indigenous healers in Sierra Leone.

The fact that the concepts of indigenous knowledge and appropriation are inappropriate to Sierra Leone leads me to the conclusion that they are Western constructs. Lemaire's discussion of the concept of culture clarifies this point:

> ...the concept of 'culture' itself, a key concept in anthropology, is a Western cultural construct. Despite its Western genesis, the concept was applied to societies that did not define themselves in terms of this concept. Because 'culture' ... typically expresses the consciousness of the modern West as producer and product of its own world of institutions, values, ideas, meanings, etc., a radical (cognitive) relativist should drop this concept altogether. [Lemaire 1991:36]

The nature of indigenous knowledge is becoming a central issue not only for academics, but also for many of the traditional keepers of indigenous knowledge and for those who might benefit materially by adapting it.

Among them are the healers themselves as individuals, groups of healers, small scale entrepreneurs, governments, biomedical doctors, external investors and multinational manufacturers and marketers.

Collaboration between biomedical practitioners and traditional healing practitioners has often been discussed as a macrolevel strategy for extending economically stretched health care systems, and also as a strategy for expanding the range of health care choices available to the public. At the microlevel in Sierra Leone collaboration is also discussed as a strategy for increasing professional recognition and income for the traditional healers.

Collaboration is often expressed, directly or indirectly, in the language of neo-colonialism and appropriation. Many collaborative programs have entailed cooperation with traditional healing practitioners without any redistribution of power (MacCormack 1986). In some cases traditional healers become low-grade paramedics with new technical skills with their traditional healing knowledge excluded from the equation. A variety of models of collaboration in Africa will be examined in this light.

The issue of indigenous knowledge as economic resource has not yet been addressed in depth, and yet the last decade of economic stagnation has forced many people to become small-scale entrepreneurs, when in other times they would have been gainfully employed until retirement. Innovative individuals are seeking low-investment techniques for increasing family income, and large corporations are seeking ways to expand their revenues through manufacture of compounds derived from traditional medicines.

The commercialising of indigenous healing knowledge is an economic, political and ethical issue. The knowledge held by indigenous traditional healers everywhere can be seen as a sacred trust to be protected and held within the ethnic group, but it can also be seen as a resource which can benefit individuals and groups ranging from the healers themselves to their communities and associations (McGowan and Udeinya 1994; King 1994). In the latter circumstance commercialisation of indigenous healing knowledge can also serve as a practical strategy for perpetuation of indigenous healing knowledge.

This study will address the issue of traditional medical knowledge as a resource in a severely depressed economy. In this first chapter I will define the nature of traditional medical knowledge in relation to biomedical knowledge. Theoretical approaches to traditional healing knowledge will be reviewed. In Chapter II the issue of collaboration will be addressed from several perspectives.

Once this theoretical framework has been established, the case of Sierra Leone will be examined. In Chapter III the data gathered during the field work in Sierra Leone will be described and analysed in terms of the key research question, the implications of collaboration for ownership and perpetuation of indigenous healing knowledge. The findings reveal that all healers have informal networks based on kinship and community while some of the urban healers have also become members of a formal organisation. The dynamics of this association, The Sierra Leone Traditional Healers' Association (SLENTHA), are examined in terms of the implications for collaboration, ownership and commercialisation of indigenous healing knowledge. In Chapter IV the discussion will summarise the arguments and issues raised and explore the overall implications of the research.

Western theoretical perceptions of appropriation, although offering a cautionary validity in North America, may be inappropriate in a country such as Sierra Leone. Instead a more practical, applied interpretation of indigenous knowledge is proposed in order to understand some of the uses to which traditional medical knowledge is being put. This perspective will be useful wherever indigenous knowledge is being subjected to this new spotlight of potential commercialisation.

Collaboration presupposes a common ground. Although this study shows that traditional healers are more highly motivated towards collaboration than biomedical practitioners, several doctors expressed an interest. The four doctors with whom I spoke in some depth requested more information about traditional healing techniques. This is a first step. It is partly with these doctors in mind that the data chapter was written. The material was collected and organised to serve as a resource for doctors (who may also be politicians and bureaucrats) and a foundation for future collaborative initiatives. The data describe the world view and cultural context of traditional knowledge, with details on techniques of diagnosis and treatment.

The Nature of Knowledge

The Western tradition of formalised knowledge has become the dominant mode of political thought in the international arena. Western perceptions of appropriation of indigenous knowledge are grounded in the hierarchy of knowledge in Western society which places abstract theoretical knowledge at the top. Theoretical knowledge is housed for the most part in academia, where it is formalized into disciplines. Access to such knowledge is controlled by gatekeepers who define the apprenticeship of students and the gradations of knowledge held by academicians. Theoreticians are usually expected to carry one or more degrees as their credentials. Approximately 20% of the Canadian population gain access to formal theoretical knowledge through university programs. In countries like Sierra Leone this percentage is much lower.

The second level of knowledge is technical knowledge. This is the specialized knowledge, including associated skills, which comprises professions and trades from medicine and engineering to welding and dressmaking. This knowledge is taught either through specialized training programs or formal apprenticeship programs. Because of the cost in time and money of training programs, access to this knowledge is somewhat limited, though it is less costly and more accessible than academic theoretical knowledge.

There is another level of knowledge, and that is what is called general knowledge, common knowledge, or folk knowledge. This is generally transmitted in less formally structured settings such as the family, peer group or community. Such knowledge is considered accessible to everyone within a culture. Literacy and education are not prerequisites. In many cultures accumulation of this kind of knowledge constitutes wisdom. This kind of knowledge is not highly valued in Western society, and even less in scientific circles.

This hierarchy of three kinds of knowledge reflects the historical class system of western Europe and the adulation and respect accorded holders of the highest kind of knowledge, the abstract. Such knowledge was the purview of the rich and the religious in medieval times, when the two were often the same. There was a direct correlation between class and access to theoretical knowledge (Erickson 1976). Rich people had time to consider abstractions, and had access to written sources of information from previous generations. Closed access to abstract knowledge was also consistent with closed access to economic or political power. The poor were not taught to read or write, and had little or no formal education. In many parts of the world, including Sierra Leone, little has changed over the centuries. The poor, including most of the traditional healers, manage their daily lives within this framework, just as non-literate people always have, developing their own systems of knowledge development, transmission and perpetuation.

Preserving Indigenous Knowledge

That this hierarchy is a Western cultural concept becomes obvious when we examine other cultures. Consideration of indigenous knowledge is useful here because it has not yet been forced into the hierarchical mould of Western scientific knowledge, although efforts are being made in this direction. Indigenous knowledge is comprehensive, integrating all aspects of the three 'levels' of Western knowledge. Such knowledge may be sorted differently within the culture itself, and the sorting might be found to correspond to the social hierarchy of the particular culture. But for the moment, indigenous knowledge is not well understood by Western academics because it is difficult to categorize (Levi-Strauss 1966; Freeman 1992). Indigenous knowledge may prove to be a model for the de-emphasis of the knowledge hierarchy in Western perception. Attempts are being made to establish that indigenous knowledge is indeed scientific, and should consequently be granted the respect that such knowledge merits (Hobson 1992; Bielawski 1992). This justification may weaken the symbolic meaning of indigenous knowledge by reducing its scope and comprehensiveness in the very act of trying to define it.

In the broad sense, by definition all knowledge is indigenous to a particular culture, and all medical systems (including the biomedical system) are part of one or more indigenous knowledge systems (Pool 1994). Within the field of anthropology the term indigenous knowledge refers to knowledge usually stored in the oral tradition of non-literate societies. Anthropology has always been committed to the collection and preservation of indigenous knowledge of minority cultural groups, often as part of what is called "salvage anthropology...[where] fresh data are run through old perspectives, from structural functionalism to conflict theory" (Barrett 1984a:238). The current commitment to indigenous knowledge is part of an attempt to decolonize anthropology, removing residual biases. Recognition of the validity of indigenous knowledge, whether in healing, technology, or any other field, is part of this movement. Without some form of approval or legitimate participation by the holders of indigenous knowledge, however, its study remains to varying degrees colonially based.

The Historical Framework for Collaboration

Collaboration between traditional healing systems and biomedical practitioners is not a new idea. At the turn of the century in India some of the prestigious medical schools combined indigenous and Western techniques (Jeffery 1982). In India as elsewhere, however, tension has grown between biomedical and indigenous practitioners as a result of internalised colonial values. The biomedical system remains the officially recognised system in many post-colonial countries. Complicated by current economic and political conditions, both global and national, this tension has resulted in a range of patterns from attempts to exclude indigenous medicine altogether to various models of cooperation and collaboration. There is a wide range of attitudes about whether or not collaboration is possible or even desirable. Some countries which were under colonial domination by western European powers still have laws on their books which nominally make traditional healing practices illegal, particularly those etically[1] defined as "sorcery" or "witchcraft". There are other settings such as China and Bali where traditional healing has for the most part avoided this stigma. Even where it has been assessed simplistically within an imposed "Western" ideology and outlawed, traditional healing has survived in rural communities throughout the world. The reason is that people continue to find uses for this knowledge; it remains socially relevant.

Collaboration, as an ideal model, implies equality between the collaborating partners: equal access to resources, both financial and political. The question, whether collaboration is possible or even a realistic or desirable goal, can be addressed from three perspectives. The first is the view of the individual practitioner, whether biomedical or traditional in orientation. The second is the view of the more distant academic, with the skills to analyze and evaluate, and to extract models. The third view is that of the patient. From this perspective the continuum of healing is unbroken by sharp distinctions. Each of these perspectives is essential to an understanding of the middle ground, the space wherein meaningful collaboration might take place.

---

[1] In anthropological parlance "etic" means the view from outside a culture, and "emic" means the view from inside.

This research indicates that if a model can be designed it will encompass the range of available knowledge including the academic and translate it into a framework of practicality, appropriateness, and economic and cultural sustainability. To examine only the macrolevel, the general or theoretical, is to miss the possibility of relevance. To examine only the microlevel, the personal or specific, is to miss any opportunity for integration and change, to become lost in anarchy. Both levels are integral to this study.

The underlying assumption of discourse on collaboration is that it is an essential part of the strategy for a successful health care delivery system, particularly in the third world (World Health Organisation 1978a and b). Full extension of technologically based biomedicine is not economically feasible; perhaps it never was. The capital intensive base which has developed in the West has made biomedicine inaccessible in its present form to rural areas in most countries of the world. If this assumption is accepted for a moment, then the only alternative is to build on what already exists in all villages, and that is the traditional healing system. The healers have been caring for the health of their relatives and neighbours since time immemorial.

Despite the pluralistic nature of health care alternatives in most countries, scientifically based biomedicine has been delegated as the formal and politically approved health care system throughout the world (Baer 1989). Traditional knowledge, although lacking in formal recognition, remains firmly established, particularly in the rural areas of the globe. Just as the politico-economic emphasis on biomedicine has been proven inadequate, similarly, a unilateral promotion of traditional healing *per se* will be ineffective, an incomplete intellectual or political exercise with no practical value (Velimivovic 1990).

The following discussion will first be set into the framework of the international policy statements of the World Health Organisation. The dualism of biomedicine and traditional healing will be addressed in the context of existing and potential collaborative models. Related issues such as regulation and professionalisation will be considered and applications and experiments in collaboration will be reviewed in the next chapter, along with the factors which influence their success or failure.

International Policy: The World Health Organisation

Almost every discussion about collaboration takes as its starting point the World Health Organisation (WHO) resolution of 1977 (1978a) which supports traditional healing. The issue of traditional healers in Africa actually moved onto the international stage in the early 1970s, appearing on agendas for the 1976 African Regional Committee Session in Kampala and the WHO Regional Bureau meeting in Brazzaville, among others. This was an acknowledgement of the persistence of traditional healing practices despite the imposition of biomedical systems throughout the developing world, and also of the failure of the latter to provide health care for the vast majority of the people it is intended to serve.

The WHO Working Group on Healers' Medicines was started in Geneva, also in 1976, and headed by Dr. Bannerman from Ghana (Bibeau 1982). The report from the meeting in late 1977 is a thorough attempt to address the issue of potential integration of traditional healing practice into primary health care. The recommendations included:

> National and international policy support for the promotion of traditional medicine;

> Collection and dissemination of information pertaining to traditional medicine;
>
> Educational programmes;
>
> Application of traditional medicine to primary health care;
>
> Manpower development; and
>
> Multidisciplinary research programme (1978a:37-39).

The general thrust of this document is to educate the community regarding the services and the efficacy (and safety) of traditional medicine, and to educate the healers themselves as "the promoters and dispensers of the new health care system in their own cultural settings" (WHO 1978:36). These ideas are echoed in a more general fashion in later documents.

In September 1978 the WHO and UNICEF[2] convened a conference on primary health care in Alma Ata, Russia. Primary health care was defined as:

> essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. [WHO 1978:4]

The resolutions from that conference added more support for programs which involved traditional healers in health care delivery. This is where the oft-used phrase, "health for all by the year 2000" originated (1978:Chapter 3, para. 17).

---

[2] United Nations International Children's Emergency Fund

Paragraph 22 of the discussion section of the same document states in part:

> High priority should be given to the development of adequate manpower in health and related sectors, suitably trained for and attuned to primary health care, including traditional workers and traditional birth attendants, where appropriate. These workers should be organised to work as a team suited to the lifestyle and economic conditions of the country.

Paragraph 82 illustrates the biomedical perspective of the resolution:

> Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well worth exploring the possibilities of engaging them in primary health care and of training them accordingly.

The actual recommendation (#9) is worded as follows:

> The Conference,
>
> Recognizing that the development of primary health care depends on the attitudes and capabilities of all health workers and also on a health system that is designed to support and complement the frontline workers,
>
> RECOMMENDS that governments give high priority to the full utilization of human resources by defining the technical role, supportive skills, and attitudes required for each category of health worker according to the functions that need to be carried out to ensure effective primary health care, and by developing teams composed of community health workers, other developmental workers, intermediate personnel, nurses, midwives, physicians, and where applicable, traditional practitioners and traditional birth attendants.

The wording of the resolutions is cautious, and arises from within the biomedical model. Slikkeveer holds anthropologists responsible in part for the perpetuation of the dualistic nature of medical anthropology, observing that "the rather isolationist interest in either traditional medicine, or subsequently in cosmopolitan medicine has not yet resulted in a balanced health development process" (1982:1860). There is a link between the dualism in anthropological theoretical models and the dualism in international policy documents that has thus far escaped the literature. These documents are often based on the academic medical and social sciences literature and put forward by doctors and academics who are the politicians from member states of WHO, UNICEF, and so on. For example, the participants of the WHO Working Group on Traditional Medicine were all medical doctors and/or PhDs. Healers were not represented. It is not surprising that the biomedical bias appears at the international policy level as well, nor that the tone is one of integration and not collaboration. Dualism creates a model of choices, of either/or, but rarely "both". Yoder observes that "implicit in these WHO proposals is the assumption that ethnomedical practitioners could be trained to work within the biomedical framework to improve primary health care" (1982a:1851). This integrative approach tends to minimize the validity of traditional healing knowledge, incorporating traditional healers as junior paramedicals in rural areas.

Nevertheless, many such projects have been funded in the past two decades, and many integrative experiments have been conducted on a local or regional level. Although success has been limited, their persistence indicates that there is interest and perhaps a valid need to pursue this line of research in order to determine an alternative model which is collaborative rather than integrative--one which does not threaten indigenous knowledge with extinction. Although there were examples of collaborative initiatives long before 1976, the Alma Ata resolution lent impetus and focus to this movement. By clothing the concept with WHO legitimacy, funding for pilot programs and ethnomedical research was more readily released. In this new climate of purpose, a number of approaches were tried in Africa. There is much to learn from what has gone before. The commitment to traditional healing at the international policy level is firm and the search for a collaborative model is far from over.

The possibility of collaboration certainly exists, as healers are drawn into training programs which make them paramedicals, or as they choose to modify their own practices to emulate biomedical techniques. However, government regulation, imposed professionalisation and restructuring of healers associations threatens the integrity of their knowledge. Bibeau warns that

> The ongoing process of official recognition and institutionalisation of traditional medicine by modern

> African states may introduce substantial changes within this indigenous institution. Conceivably it could lead to the alienation and death of this ancient art of healing. [1982:1843]

The intent of the international policy-making bodies is to acknowledge the potential to include traditional healing as a strategy for developing a more comprehensive health care system. Within the dominant biomedical models alone this cannot be accomplished by the year 2000. The World Health Organization has recognized the need to include traditional healing in any realistic solution (1978), but a sustainable and transferable model for effective collaboration in Africa has yet to be identified. Yoder warns against seeing traditional healers as merely a "stop-gap measure until biomedical care can be expanded" (1982a:1856).

> Indications are that the WHO still adheres strongly to laboratory medicine and to the relatively cheap but ineffective 'search and destroy' tactics to which it leads. For a variety of reasons however the past decade has seen the development of a new interest by the WHO in more community based and less technological forms of medical care. This trend reflects the changes taking place both in the nature of imperialism (particularly in the mode of economic exploitation of the third world) and also in aspects of the social structure of underdeveloped countries themselves [Doyal 1979:276]

This, then, is the usual starting point for discussions of collaboration, the dualistic model of two systems: biomedicine and traditional healing. The full extent of the problems and potential for collaboration cannot be understood without an exploration of the nature and utility of this dualism.

A Discussion of Dichotomy: Biomedicine and Indigenous Healing Knowledge

In Defense of Dualism

A comparison of biomedical practice in Africa with indigenous healing practice reinforces the utility of the dual model. The distinction is real in policy discussions and provides a useful tool for understanding similarities and differences, and the reasons for the persistence of the dualistic model.

Ethnomedicine, and indeed much of anthropology, is also reductionist (Baer 1989) in that the categories which permit us to construct comparisons require imposing an external order. This process must exclude much, even as it defines what is to be included. It is also an essential intellectual tool. Communication can only take place within an accepted framework of definitions and assumptions, and dualism, once its weaknesses are acknowledged, offers a utilitarian framework. Lemaire points out the utility of an academic language:

> From a radical emic position, anthropology as the comparative science of humanity is impossible; it is reducible to a series of mutually incomprehensible and incommensurate ethnographies. On the other hand, a general science of culture needs concepts and categories that transcend particular cultures. As anthropology was born in modern Western civilisation, it was only natural for it to borrow its concepts from the emic idiom of the West, especially from the language of its self-description and self-analysis in political economy, political philosophy and the philosophy of history. [Lemaire 1991:36]

There is both an apologia and a strong justification for analytical categories, particularly if at the outset we acknowledge that the categories may not be representational (Friedman 1991). Jeffery's caveat at the beginning of his article on policies toward indigenous healers in India is that "there may be no clear relationship between official discussions of indigenous healers and the situation 'on the ground'" (1982:1835.) First the apologia: academic realism tempers the argument here. Funding for research comes from agencies and governments with their own agendas. To qualify for funding academics must define their projects within the criteria of the granting bodies. A positivistic stance, described in biomedical terminology, with a clinical application, is more likely to receive support from the large health research institutions than a qualitative anthropological research project. This may have been an indirect factor in the minimization of supernatural aspects of traditional healing knowledge in the literature, and

> ...the 'discovery' that Africans really have a medical system and that it looks basically just like ours: naturalistic, empirical, pragmatic, disease-oriented[.] Here medical anthropologists may be repeating the surreptitious appropriation of indigenous discourse that certain scholars of religion perpetrated before them when they 'discovered' that the pagans had believed in one 'High God' all along..., thus reducing indigenous tradition to the shape and interest of Western biomedical and anthropological discourse. [Pool 1990:15]

Although this may not excuse the emphasis that the dualistic model has received, it helps to explain it in terms that most academicians can understand. Funding agencies have only recently begun to address multicultural health and plural health care systems.

The prolongation of dualistic models can be justified in another, equally practical fashion. Without some delineation it is not possible to discuss the question of legitimation or collaboration. Warren (1989) and Good (1987), among others, argue that identification of a discreet body of knowledge is essential for policy development. Perhaps the issue is not the necessity of such models, but their validity. Periodic accountability of those who employ the reductionist models to those who operate within them can provide balance. This may entail the production of more complex models, or simply a new approach. Otherwise policies run the risk of being developed in a vacuum, based upon simplistic and reductionist representations of indigenous practice. Realistic policy development is dependent upon a reasonable presentation of the attributes of indigenous knowledge. This needn't be inordinately complex, adding more layers to existing approaches. An example is the analysis of Javanese disease/illness knowledge in which Lyon advances a "larger notion of order...linking cognitive and biological order" (Lyon 1990:255). She is expanding from the accepted base of dualistic models to more closely reflect what she found in the field.

Biomedical and Indigenous Healing Practice: A Comparison

Biomedicine is euphemistically called hospital-based medicine in much of the third world literature and is understood this way at the community level. It is perceived as being strongly associated with the infrastructure of buildings--hospitals and clinics--and on technologically sophisticated equipment such as x-ray machines and operating suites. Since the 1970s there has been a concerted effort by national governments and the international community to extend primary health care to the periphery. The example of the barefoot doctors of China (1977) is often cited as a model for extending health care to the village level. This approach, however, is culturally-based, and does not transfer well to other countries. When it was applied in Iran the hierarchical structure of the society was such that the auxiliary personnel were considered a threat to the doctors who strongly resisted the program. Further, unlike China, the village structure of Iran makes impossible democratic elections of the health workers as in the Chinese model (Doyal 1979).

Other attempts have been made to apply similar models in rural areas. In Tanzania (Nuru 1994) there were also culturally-related problems:

> Rural health workers...exhibited distinctly negative attitudes towards the local people, whom they tended to regard as uncivilised, ignorant and stubborn. Instead, they identified strongly with the richer peasants and, despite their special training, sought their inspiration from the 'real' doctors at the top of the

> medical hierarchy. As a result, instead of facilitating perceptible improvements in health, rural medical schemes have tended once again to founder through their close reliance on the Western model of medical practice. [Doyal 1979:289]

There is now an extensive literature on community-based primary health care. It has been acknowledged, however, that health care cannot be extended to everyone on the planet with the present model. The biomedical system is too unwieldy and too expensive to reach the vast numbers of people in the rural villages of the world.

Biomedical Practice

The prestige and knowledge power attached to the position of medical doctor forces a power differential between patient and physician (Moore et al 1980; Armstrong 1982; di Giacomo 1987). Derived from the Western scientific model, this approach to health care is also biologically deterministic (Lewontin 1991).

There are characteristics inherent in the biomedical model which limit its effectiveness outside a cause and effect arena (Comaroff 1982). There is an assumption of stability in biomedicine in a general sense. The core of knowledge is such that most disease conditions, having been identified and tamed, will not change, and the description in the medical textbooks will be accurate for generations of doctors to come. Disease conditions are often named after the doctor who first described them, such as Hanson's disease, Huntingdon's Chorea, and many others (Shapiro 1978). The classical descriptions are still memorized by the students, implying a certain immutability and predictability about disease causation and manifestation that is not sustained in practice. The "prevailing unifactorial models of disease" (Comaroff 1982:61) cannot accommodate the full range of illnesses. New diseases and new patterns of old diseases are common. There are several reasons for such change:

1) disease causing organisms adapt to new conditions
    - -they develop resistance to drugs, as in the case of malaria
    - -they mutate spontaneously, resulting in more virulent forms (AIDS)

2) disease causing organisms die out or become less virulent through selection, because they can no longer adapt to a changing external environment (TB, bubonic plague).

Epidemiology has revealed that medical science claims more than its fair share of credit in eradicating some diseases which have vanished or become relatively harmless more for reasons such as the above than because of medical break-throughs (Dubos 1980; Comaroff 1982; Golub 1994). As Yoder notes, however, "Health experts now recognize that the dramatic improvements in the health status of the populations of industrialised nations stem more from changes in life style and measures of preventive medicine than from curative services offered" (1982a:1851). Lewontin points out that:

> In countries like Brazil today, infant mortality rises and falls with decreases and increases in the minimum wage. The immense betterment of nutrition also explains the drop in the higher rate of tuberculosis among women than among men. In the nineteenth century, and even long into the twentieth in Britain, working men were far better nourished than homebound women. Often if meat could be afforded for the table in an urban working-class family in Britain, it was saved for the man. So there have been complex social changes, resulting in increase in the real earnings of the great mass of people, reflected in part in their far better nutrition, that really lie at the basis of our increased longevity and our decreased death rate from infectious disease. [Lewontin 1991:44-45]

While diseases of an ageing population are the issue for industrialised countries of the West, infectious diseases directly related to poverty continue to limit the lifespan of those in Third World countries. Transition from the herding or foraging economies to marginal capitalism has caused a serious reduction in nutritional status and resistance to diseases. The current resurgence of tuberculosis among the poor provides unfortunate evidence to support this (Epprecht 1994). Socio-political causes of illness, poverty and marginalisation, are overlooked by scientific medicine (Scott and Conn 1987).

Fields of medicine which address these factors are not mainstream and cure-oriented and are marginalised to one degree or another (Townsend and Davidson 1980). Conditions which are not caused directly by an identifiable agent are often categorised as organic, psychogenic, neurotic or hysterical. Anything beyond rudimentary psychiatric knowledge is considered unnecessary to practitioners in other fields of medicine.

The relatively new field of environmental medicine is also considered marginal and the conditions are often attributed to allergies (Ware 1992). Some of these illnesses are caused by multiple agents. The biomedical approach cannot readily encompass diseases caused by combinations of factors, where each agent is below the causative threshold, as in multiple chemical sensitivity conditions (Regush 1987).

There are many reasons why biomedicine will not reach everyone by the year 2000. First of all, biomedicine is urban in nature (Scott and Conn 1987). In developed nations as well as the third world, Western trained doctors prefer to work in the cities and not the hinterland. There are better support facilities in the cities, and a wider range of paying patients. In the rural areas throughout the world poverty influences the ability of patients to pay for services, and the lower tax base limits the installation of clinics and hospitals (Townsend and Davidson 1980).

Related to this urban centralisation is the problem of proximity. In *Catch-22* fashion rural people tend not to use the biomedical system because the facilities are often too far away and too expensive. Conversely, it is expensive to extend the biomedical system to the periphery because of the decreased density.

The ideological gap is also a factor, in that patients may be reluctant to visit a nurse or doctor after they have been treated by a traditional healer, as they may face harsh remonstrations for having done so. Patients assume that most biomedical personnel see traditional healing as sub-standard and unscientific.

Yoder (1982a) adds to this list of factors with the observation that training of biomedical personnel is inappropriate to the rural settings in which they would be required to practice. They are often drawn from the wealthier classes of society and have been educated within a Western paradigm. They have grown up in urban settings and have had little exposure to traditional ideology and healing practices. Such cultural barriers can mitigate against a full understanding of the social causes of an illness.

Traditional Healing Practice

In Africa most traditional healers practice in the rural villages (Yoder 1982b). Although some support their families from their profession alone, many have farms and other small businesses that are village-based. In stable, peace-time conditions traditional healers are integrated into the community they serve, drawing their clientele from within the kin group. Their patients live near-by, and the socio-cultural factors which may influence the health of the patient are generally well-known to the healers.

Traditional healers are perceived to be less expensive than biomedical practitioners. This still tends to be true in the rural areas, although I found that some healers in the cities are said to be charging rates comparable to their biomedical counterparts.

Payment is rarely demanded in advance by traditional healing practitioners (THPs). Their charges tend to be flexible, with many accepting payment only upon satisfactory conclusion of treatment. This payment may be in the form of food or even labour. Payment can also often be postponed.

Traditional healing is not only curative, but preventive and even predictive. Those who include divining in their lexicon of skills can foretell the future progress of an illness.

This brief framework for consideration of traditional healing will be expanded in the next chapter as the nature of traditional healing practice is a key element in this study.

Discussion

Biomedical knowledge is directed at detecting the causative factors in disease in "nonpersonal and nonteleological" terms (Armstrong 1982), while traditional healing knowledge "postulates theories or causal connections in personalized, purposive terms" (Green 1980:492). Green generalises that biomedicine is better at treating disease while traditional medicine is better at treating illness (1980:493).

A distinct advantage to biomedical knowledge is its transferability. Its principles and theories are applicable anywhere in the world, whereas traditional medicine tends to be grounded in local cultural beliefs and patterns.

According to Green, "Given the availability of both modern and traditional health services, most Africans use both--even urban, educated Africans.... One reason for this is that even if a modern health worker can cure a disease, the patient's illness still requires treatment" (1980:494).

There are also ideological constraints to collaboration. The technologically oriented groups in most countries defend biomedicine as an exclusive, definable, contained discipline, an integral part of the dominant politico-economic pattern of power. In Africa loyalty to biomedicine is sometimes linked to the growth of post-colonial nationalism, as governments strive to establish internationally accepted standards with their institutions (Jeffery 1982). There are economic factors which influence the exclusivity of biomedical practitioners, as well. Even medical doctors who have been raised in rural villages where the only healers were traditional become somewhat defensive when collaborative models, as opposed to integrative, are discussed. The prestige and economic affluence ascribed to their profession is dependent upon the exclusivity of their knowledge which is the base of their power.

Traditional healers also have power and prestige and an appropriate kind of economic power within their own milieus (MacCormack 1986; Reynolds 1986). An equitable model of collaboration will preserve this power, although it may require compromises.

To discuss the issue of collaboration without examining the cultural setting, the values, beliefs and rewards, of all healers, is to put the cart before the horse. Successful collaboration requires that we discard the perception that "basically there are two systems of health care in the developing world: one is traditional, pre-scientific and ethnic; the other modern, scientific and Western in its derivation" (Good 1979:141) and abandon our predilection for organising other people's knowledge to suit our own models (D'Andrade 1973).

Deconstructing Dualism: The Patient's Perspective

My work in Sierra Leone certainly underlines the artificiality of defining a monolithic and discrete ethnomedical system. Even the word 'healing' is an etic imposition in that perceptions of well-being are complex and culturally significant.[3] The WHO definition of health, "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (quoted in Encyclopedia Britannica 1973 X:751) is based on Western perceptions of differentiations between emotional, physical and spiritual well-being and the absence of disease. The absence of disease does not have the same level of cultural meaning in a country where by Western definitions most people are sick most of the time (Gibson et al 1976). Further, D'Andrade's work in Mexico shows that

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[3] The term "traditional healers" is potentially a misnomer, confining discussion to those aspects of the practitioner's repertoire which are construed as healing. This assumption excludes

> The Mexican informants appear to organize their beliefs about disease in a different manner than US Americans. One major concept appears to be the hot-cold dimension of illness and medicine. Other clusters center around ideas concerning epidemic illnesses affecting *children* (measles, smallpox) in contrast to diseases more likely to affect *older people*, including witchcraft and certain intestinal disorders. One striking finding is that the range of disease considered contagious is very much more limited among the Mexican respondents, with dysenteries and respiratory infections apparently not considered to be especially dangerous. [1973:125]

Different classifications of illness are referred to healers with appropriate skills. From the perspective of the patient, then, a pluralistic model of health care is closer to reality (Jacobson-Widing and Westerlund 1989; Leslie 1980). From a policy-making perspective, however, and from the point of view of members of the biomedical professions and the traditional healers themselves in African countries, the dual model still serves.

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the skills of sorcery and divining which are not necessarily consistent with an etic definition of healing.

In countries where Western biomedicine has been the dominant model, there has recently been a shift on the part of the clients to tentative exploration of alternatives (Aung 1994). In Alberta, Canada, this is reflected in recent legislation which made the practice of midwifery legal. This overt change followed a law suit where a midwife was charged with practising medicine without a license. She was acquitted when the judge decided that pregnancy is not an illness.

In Canada and elsewhere this gradual shift toward alternatives has been sometimes covert because of the political ideology that implies that traditional healing knowledge is simplistic, even primitive. In Africa this kind of secrecy is only practised in the presence of biomedically trained personnel. Within the community traditional healing is part of daily life, an integral element in the social construction of reality.

Although eighty percent or more Africans continue to use traditional healers (Green 1980), the legacy of colonialism (Lambo 1977; Singer 1977; Vaughan 1991), often reinforced by education in Western universities or derivative systems and institutions, retains a hierarchical perception of traditional healing as sub-standard, or as folk medicine, when compared with biomedical practice. This is why the local perspective is an essential component of discussions of collaboration. When examined from the perspective of the clients, one quickly discovers (see Slikkeveer 1982) that a continuum rather than a duality has always been real on a practical level, and the continuum is inclusive of all the subspecialties of biomedicine, alternative practices[4] and indigenous healing available to the patient.

The distinctions between biomedicine and traditional healing are not dichotomous in Sierra Leone. A simple fracture can be treated by a traditional healer more effectively than by a medical doctor; but a compound fracture requires biomedical intervention--specifically, surgery. There are many other examples which force the inquisitive observer to reshuffle the deck of healing knowledge, while the dualistic model forces a rejection of one kind of knowledge or the other. An acceptance of the power of choice from a client's point of view permits a more complex examination of the full spectrum of healing knowledge.

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[4] Alternative practices include other recognised treatment practices such as ayurvedic, acupuncture, homeopathy, naturopathy, iridology and chiropractic. They will not be addressed in this paper, but merit mention here as part of the health continuum, and the range of choices available to client populations in various cultural settings.

Classification of Indigenous Healing Knowledge: A Base for Collaboration

There have been many attempts to categorize indigenous healing knowledge peppered through the literature (Yoder 1982b; Good 1987; Zeichner 1988; Masi 1994). Categorisations of healing knowledge are artificial constructs (D'Andrade 1973), since healing knowledge, in my experience in Sierra Leone, cannot be separated from spiritualism, food, social behaviour and the whole cultural fabric (Young 1994). To do so is incomplete, unidimensional and misrepresentational. Based on a re-examination of Evans-Pritchard's study of the Zande and subsequent references to it, Pool concludes that "descriptions of 'medical' systems are not more accurate representations of how Africans interpret and cope with illness but biomedically determined constructs which are imposed on African culture in medical ethnography." He concludes with "a plea for the dissolution of the concept of 'ethnomedical systems'" (1994:1). Nevertheless, the search for common ground, a place to start the dialogue on potential collaboration, often starts here.

Some authors try to create a general typology of skills, attempting to find analogies with biomedical specialties, while others describe the distinctions they see in a particular setting. Since many healers practice more than one "type" of healing, the classification process sometimes creates more problems than it solves. For example, Chavunduka (1986) identifies eight categories of healer in Zimbabwe, but many of these are simply combinations:

> The first category are spirit mediums (spirit-diviners). The second category of traditional healers consists of what are generally known as herbalists (pharmacists)....The third category...consists of those spirit mediums who are also herbalists....The fourth category...consists of general diviners....Many general diviners also treat [as well as diagnose] their patients, and this is our fifth category....The sixth category...consists of midwives. But there are midwives who are also herbalists; this becomes our seventh category. The eighth category consists of those who are generally known as faith healers.
>
> Within each category are specialists. There are, for example, healers who are highly skilled in divination. Other specialists are noted for their skill in the treatment of children's diseases. Some specialise in women's illnesses, while another group are noted for their treatment of epilepsy, there are also specialists in the field of mental disorders and so on. [1986:32-34]

There is a certain reluctance in the literature to address the role of spiritualism, magic and witchcraft[5] in the process of healing and a tendency to focus only on the more tangible, comparable categories such as herbalism. Huizer points out that

> ...there is considerable resistance to finding ways adequately to understand witchcraft, magic, trans, spirit-possession and similar phenomena. These do not seem to fit scientific paradigms, but appear to 'work' in certain contexts. It is a seemingly typical Western rationalist 'belief' that it is possible to distinguish clearly between these various phenomena, while in other cultures they are experienced as related or fundamentally intertwined. [Huizer 1991:51-52]

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[5] In the anthropological literature these aspects of culture are often considered under the general category of religion, rather than healing.

Thus, despite our careful attempts to sort and classify healers, we still do not arrive at a clear pattern for comparison with biomedical knowledge.

Another approach is to classify the sources from which various healers obtained their knowledge. In Sierra Leone there are three main sources of healing knowledge: self/spiritual, apprenticeship and formal training. Those drawn from the first group are highly individualistic; those in the second group only slightly less so. Those in the third group, also the smallest group, are more likely to be amenable to organizational directions.

Masi classifies healers by belief systems: "1) beliefs in nature or natural causation of health and illness; 2) beliefs relating to the self as affecting health; and 3) beliefs in the effects of supernatural forces on the health of individuals" (1994:4). These categories are not always discreet, though. A healer with whom Mburu worked in Kenya points out the overlap in beliefs, which may not be immediately evident.

> That particular diviner-cum-herbalist said the cause of measles, pertussis and acute diarrhea are similar. They are caused by a reddish brown worm lodged in the stomach just under the spleen. This is the ordinary or the natural cause. But the ultimate cause is another; that is, these childhood diseases could spring from varying causes. Evil men, for instance, or the negation of socio-religious obligation may result in one or two diseases. Those who bear a grudge against others are likely to curse or use fetish powers to cause harm on whomever they like. The fetish could result in any of the diseases. [Mburu 1977:178]

It is generally agreed that biomedical personnel are more likely to work with herbalists than with sorcerers and diviners. This is based on an affinity for a curative approach and the knowledge that many drugs are derived from plant sources.

The herbal component of a healer's knowledge most closely resembles a scientific model. Green concurs, noting that "...healers of the most naturalistic orientation seem to be the best candidates for collaboration with modern health practitioners" (1980:507). This is illustrated in Sierra Leone where the medical college has a department of pharmacognosy in which a herbalist teaches the medical students about medicinal plants and their uses. This course has been in place for some time, and has no connection with the Association for Traditional Healers except that the instructor is also an inactive member of the association.

Applying Classification: Registration Programs

Collaboration at the institutional or macrolevel involves at least two discreet bodies or organisations. Identification of the potential participants is the first step. Biomedical personnel are generally registered with professional associations. Registration of traditional healers can be conducted by government officials or by membership subscription to a healers' association.[6]

The initial purpose of government-initiated registration is usually to produce revenue. The healers pay a fee for registering which goes into the coffers of the government or professional organisation (or into the pockets of the registrars). The list can easily be used as a tax roll for later collection of income taxes. Warren (1974) found in Ghana that many herbalists preferred not to register to avoid subsequent taxation.

The process of registration raises the question of classification once again. This is accomplished fairly informally, with the healer or the registrar selecting from a list of pre-determined categories. This somewhat arbitrary and subjective process can lead to some very misleading statistics, particularly since most healers also engage in other income-producing activities.

On a larger scale, there are opportunities for abuse of registration systems, particularly if professional associations want to be seen to have a large membership of registrants. Thousands of names can be collected without payment or further involvement.

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[6] With a few illustrative exceptions the models in this study are limited to the literature on Africa. At a very general level there is a shared history of European colonialism among most African nations, during which time biomedicine became the medical system preferred by colonial and post-colonial governments.

Registration can also create fear and anxiety among the traditional healing practitioners (THPs). Many healers who have not registered for economic reasons are concerned that they are practising illegally. Others are convinced that registration protects them from liability in potential malpractice predicaments.

Chavunduka (1986) notes that there can be many practical problems with registration procedures. Illiteracy of many practitioners makes registration a complicated and intimidating process. Distance from the registry site creates problems for some of the older healers.

The classification process within the registration process can be instructive. In Sierra Leone licensing lists the full range of a healers' skills, as negotiated by the healer within the confines of available categories for official registration. For example, the registration of one Kenema healer reads as follows:

> This is to certify as contained in the Kenema Town Council receipt number 11873 on the 14th of March 1988 hereto attached that Madame Alice Kamanda of #26 A Fyeia Street of Kenema, Nongowa Chiefdom, Eastern Province of the Republic of Sierra Leone is a recognized herbalist, occult and sorcerer who can discover hidden and stolen properties, and sees by means of magical broom, and pieces of metal, and can perform mysterious healing for which she is authorized under the Kenema Town Council Ordinance CAP AD Section 8, (14) part 1 and issued license number 11873 on the 14th March 1988. The license which is not transferable does not entitle its holder to molestation or any

> peaceful criticism and will expire on the 31st of December 1988. [7K][7]

Registration can also be a source of pride, providing an assurance of personal legitimacy affirmed by government recognition. It can also establish a base for collaborative training programs or the membership base for an association of traditional healers.

Strategies for Collaboration

Expanding the Repertoire: The Microlevel[8]

One of the most successful models for institutional collaboration has been based on extending the healer's repertoire by the addition of biomedical techniques (Neumann and Lauro 1992; Maclean and Bannerman 1982).

Traditional Birth Attendants: A Public Health Initiative

Seventy percent of births in Sierra Leone occur outside biomedical health facilities (Amin et al 1992; Ross 1988). Institutional collaboration has occurred between the biomedical sector and the Bundu Society: the women's secret society. In a pilot study in Sierra Leone "...tetanus immunisation was introduced as a ritual element in girls' puberty rites, with the full cooperation of high officials in the women's initiation society, who are also local midwives" (MacCormack 1986:156). Those administering the vaccine were not regulated in any way. Their practice was enhanced by a procedure which was easily integrated into the age-old ritual at the village level, without the establishment of an additional bureaucracy of any kind. MacCormack suggests that "...if local midwives were taught to give vaccines, they might administer them as part of the naming, or stepping-out ceremonies that often mark the beginning of an infant's social personhood" (1986:156). This appears to be a practical and inexpensive avenue for public health initiatives.[9] Public health practices can be integrated into the spiritual and ritual life of the community with minimal effect on the traditional practices (Davies et al 1992).

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[7] This coding system is used throughout the thesis whenever material from interviews is cited. In this case the material is taken from transcript of the seventh healer interviewed in Kenema, i.e. 7K; 10F is the tenth healer interviewed in Freetown.

[8] The micro/macrolevel model (DeWalt and Pelto 1985) is another useful dichotomy, like biomedicine and traditional healing. Its limitations as an analytical framework are much the same in that the levels are not always discreet.

In Haiti a similar approach has been initiated:

> Cost data suggests that the programs for training traditional birth attendants in modern preventive health care is an inexpensive way of improving the life chances of poor rural mothers and children. The enthusiastic acceptance of training by indigenous midwives,and the positive response by rural mothers, suggest that pessimistic arguments by some social scientists about the "traditional" mentality of rural people in Haiti needs to be reconsidered. The findings

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[9] Incorporation of health procedures into ritual events has long been practised in Canada. A test for syphilis is mandatory before the marriage licence can be issued.

> of this survey shows that simple, appropriate primary health care interventions, when carefully introduced, can be easily accepted by rural people. The potential for basic primary health care interventions is great and much can be done even with very limited resources. [Allman 1986:57]

Carolyn Sargent (1988) noticed that in Benin midwives were not considered eligible for membership in the Association of Traditional Healers. This would be understandable, perhaps, if we assume like the Alberta judge that birth is not a disease. And yet their role in rural cultures is central. In Ghana, for example, "traditional birth attendants focus on life crises. They have a special role to play at birth and at puberty ceremonies. In child birth, they are the midwives and they are also recognised as godmothers to young children. Throughout Ghana, especially in the rural areas, they are known as specialists in obstetrics. Their range of activities extends into the field of sex education and contraceptive counselling" (Twumasi and Warren 1986:118). Over two-thirds of the world's infants are currently born at home, attended by indigenous midwives (Allman 1988:49). Expansion of their services rather than replacing them or moving them to hospitals and clinics, is logical and culturally appropriate. In Sierra Leone the midwives, or traditional birth attendants, often have a healing repertoire which extends beyond deliveries. Several have joined the healers' association in Freetown.

Oral Rehydration Therapy (ORT)

Another example of expanding existing knowledge is to teach healers to use oral rehydration therapy in cases of diarrhea, particularly in children (Green et al 1989). Packages of the salts prepared by UNICEF have been distributed to healers in many countries, although Green reports that the ORT project in Swaziland is "stalled" (Green 1982). The healers are gratified to be able to use the technique. One of the healers with whom I worked treated diarrhea with a mixture of water, salt and sugar very similar to the UNICEF salts. She would find the ready-mixed version most convenient. Unfortunately, however, the rehydration salts are also an efficacious hang-over remedy and in many locales this represents a more lucrative market than distribution to health personnel (personal communication, WHO doctor).

The above examples of expanding the healers' repertoire with add-on techniques does not diminish the integrity of the indigenous knowledge base of the healer. The pre-existing professional knowledge is recognised as a justification for adding on an additional technique. This is a key element of true collaboration.

Mental Illness: A Cooperative Model

A key criticism of biomedical practice is that it does not integrate culturally based psychosocial factors well.

Green goes so far as to say that "modern psychiatry--a term virtually synonymous with Western psychiatry--may have no clearly demonstrable superiority over traditional techniques in broad areas of mental illness, *at least for traditional Africans*" (1980:495). Integration of traditional healers skilled in this area is a logical move as, according to Suryani and Jensen, "many reports in the literature describe how culture and Western psychiatry can be integrated in the process of understanding and evaluation of clinical disorders, there are few clinical examples of actual integration of therapeutic strategies" (1992:301).

It is generally conceded that traditional healers are more successful in treating Africans for mental disorders than psychiatrists are, even those with cross-cultural training. Green observes that

> No one seems to contest the fact that healers currently play a vital role--in fact the major role--in treating and managing mentally disturbed Africans. However, there is considerable debate over whether healers should be encouraged or discouraged by the modern health sector, collaborated with or ignored, trained paraprofessionally or legally restricted from practising at all. [1980:489]

The spiritual/religious causation of mental disorders is part of many indigenous belief systems, and is not stressed in biomedical explanations.[10]

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[10] Collaboration has been achieved in Bali between the practice of psychiatry and traditional healers, but this cooperative model is not uniform. Suryani discovered four levels in her survey. Sometimes the healer comes into the hospital and treats the patient in concert with the psychiatrist (one case); the healer may continue to treat the patient while referring him/her for

There is a wide range of examples of microlevel collaboration, such as mutual referral among traditional healers, and between individual traditional healers and biomedical personnel, including nurses, doctors, pharmacists, and others. Many of these will be illustrated by the data analysis to follow.

Professional Associations

Professional associations often become *de facto* vehicles for collaboration between biomedical and traditional practitioners. In many cases this is exemplified at the institutional level by the initiators of the associations, whether government officials (Glasser 1988) or private citizens, being biomedical doctors (Pearce 1982).

Because the healers tend to be individualistic, professionalisation of traditional healers is almost always externally imposed. The common motivation for seeking membership is to establish legitimacy so as to increase income. There are other reasons such as sharing technical knowledge, pursuing joint activities such as research and

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concurrent treatment by a psychiatrist; hospital patients attend traditional ceremonies outside the hospital during their in-patient treatment; and finally, the psychiatrist refers the patient to a healer concurrently with psychiatric therapy. This model deserves consideration because collaboration did not involve integration into the western medical milieu nor the reverse. As with the add-on models, neither field of knowledge is ignored, threatened or diminished.

establishing clinics, and attracting new clients (Last and Chavunduka 1986).

Traditional healers' associations tend to be located in urban centres. There is a tendency for them to become more cosmopolitan, and some healers begin to charge fees, emulating biomedical practitioners. The transition to cash payment is a strategy to compete with biomedical practitioners in urban settings. It is also a strategy for ensuring payment in a less personal (traditional) kind of practise. In many African countries currently experiencing civil unrest and displacement of people, many healers charge cash payment for patients whom they do not know well. Cash may become the preferred mode of payment, as traditional social controls which ensured payment are eroded by displacement, competition and professionalisation. Professional associations are often imposed by governments in Africa to meet the need for regulation in the face of dissolving traditional mechanisms for social control.

Government can play either an initiating or supportive role in professionalisation. Where government initiates the professional organisation, the motivation tends to focus on regulation and quality control. This can be accomplished by a direct extension of the registration process. It is rarely done, as thus far most governments have chosen to play an informal, passive role, acknowledging the presence of traditional healers, but leaving the sticky issues of screening and quality control to the healers themselves.

A key argument for professionalisation is control of malpractice. Although this is an acknowledged problem in biomedicine, there is a mystique that traditional healers "...are by custom morally responsible to treat the sick and the poor. Thus it is inconceivable for a traditional healer to give inadequate attention or completely refuse care to a poor sick person" (Fosu 1988:98). This is idealistic, as fraudulent practice occurs in both traditional and biomedical settings, and protection of the public is a common goal. The issue of quality control may be a red herring, however, since charlatans are unlikely to want to join an association for fear of being discovered or regulated (Green 1980). Chavunduka (1986) tells us that in Zimbabwe any potential for negligence is sanctioned by fear of retribution and withdrawal of skills by the ancestors. Professionalisation can address the issue of control, but there may be other solutions.

With the impetus of the WHO resolutions and the possibility of project and research funding, various individuals have attempted to establish associations of traditional healers. Sometimes it is a group of medical doctors and academics; sometimes it is liberal-minded citizens; and occasionally it is the healers themselves, although this is much less frequent.

In 1984 there was no formal healers' association in Swaziland. Green and Makhubu submitted a detailed recommendation to the Ministry of Health in support of the establishment of such a body. The hierarchical structure that they suggested would have a national committee, district committees and local committees. The national committee would have two healers from each district. The rest of the positions would be held by government officials, with the Minister of Health as the Permanent Secretary. The purpose of this proposed professional association would be

> ...to establish a continuing dialogue between healers and government, help disseminate information among and between healers, and improve the quality of healing practices....The formation of an association should be viewed as a way of promoting rather than directly controlling healing practices. [1984:1075]

Carolyn Sargent, in her study of Benin healers, observed that if the professionalisation is being imposed by outside forces, or if it is not occurring in response to a need on the part of the healers, it is likely to be unsuccessful:

> The formation of an association essentially violates the individualism characteristic of Bariba medicine, while a movement to stimulate collaboration among healers--sharing of techniques or knowledge of substances, for instance--would sharply contradict prevalent views concerning secrecy in diagnosis and treatment as well as the tenets of the apprenticeship mode of recruitment....Finally, ...Bariba healers do not traditionally sell medications; thus an association to commercialise medicine or to regulate fees does not provoke immediate interest in this population. Creation of a structured association, then, does not seem to be especially relevant or advantageous to the 'professionalisation' of Bariba healers, in that the imposition of an association might dramatically alter

> essential features of Bariba healing practice. [1986:145-146]

In sum, from the point of view of the traditional healers, there is much to lose and little to gain from professionalisation. There is the question of loss of prestige if the association is controlled directly or indirectly by medical doctors; there are structural shifts contradictory to traditional philosophy, such as beginning to quantify and charge for healing services and herbal substances; there is the dilemma of imposing uniformity in training and professional status to people who pride themselves on their unique individual knowledge built up over a life-time; and there can be unresolvable ethical differences in what constitutes appropriate treatment such as the extreme example cited by Ngubane (1988) of prescribed 'ritual murder'.

There are, however, some advantages to professionalisation, such as the opportunity for sharing knowledge, cross-referrals, and the potential for financial benefit.

The following section examines several African healing associations including the Sierra Leone association, providing an opportunity to see how the above factors are manifested.

Four Models of Professional Healers' Associations

The Zimbabwe model: ZINATHA

Legal recognition of traditional healers in Zimbabwe occurred in 1981 with the passage of *The Traditional Medical Practitioners Act,* No.38, 1981. The Act established the Traditional Medical Practitioners Council, which has four objectives:

> a) to supervise and control the practice of traditional medical practitioners;
>
> b) to promote the practice of traditional medical practitioners and to foster research into, and develop the knowledge of such practice;
>
> c) to hold inquiries for the purposes of this Act; and
>
> d) to make grants or loans to associations or persons where the Council considers this necessary or desirable for, or incidental to, the attainment of the Council. [Chavunduka 1986:35]

The text of the Act promotes a strong formal link between government and traditional healers in Zimbabwe. Membership on the Council of twelve includes seven members appointed by the Minister of Health after consultation with the Association of Traditional Healers and five who are elected by all registered traditional healers.

The Act also encourages the formation of the healers' association. Prior to 1980 a variety of small associations existed, many lacking leadership and perceiving each other as competition. ZINATHA was formed as a result of a meeting organised by the Minister of Health, and from then on all other associations ceased to exist.

ZINATHA is organised in hierarchical fashion with considerable local autonomy, much like the model proposed by Green and Makhubu. It has a research department which was not very active due to shortage of funds, and an education department which was very successful for some time.

> By 1983 the association had two medical schools and four clinics. At these schools students are taught the various uses of plants and other medicines. They are also taught hygiene and simple bookkeeping. Spirit possession is not taught. The medical course lasts one year. Graduates who are interested in practising medicine on their own spend another three years or more working in the clinics run by the association where they gain further practical experience. ...Profits made, if any, are shared equally between the students and their instructors. Instructors get an additional allowance from the association. [Chavunduka 1986:38]

The association also serves as a regulatory body, enforcing discipline for a variety of offenses such as fraud, incompetence and improper conduct. There is a code of conduct which stipulates, among other things, that advertising is forbidden. In practice this is observed more in the rural areas, where face-to-face contact ensures that the healer's knowledge and availability will be well-known. In the cities many practitioners choose to advertise.

As exciting as this program appears, there were subsequent problems due to residual opposition within the Council to recognition of the healers. The two medical schools had been temporarily closed for lack of funding because of tensions and shifting priorities on the national level.

The Ghana model: GPTH

The Ghana Psychic and Traditional Healers Association (GPTH) is another example of a national association of traditional healers. Inaugurated in 1969, and expanded in 1973 to include traditional priests and priestesses, the government of Ghana recognizes this nation-wide association. There is also a government supported Centre for Scientific Research into Plant Medicine where the most effective collaboration has occurred

> ...traditional healers--both herbalists and priest/priestesses--work together with physicians from the Ministry....the Centre conducts studies on the pharmacological action of many herbal remedies, as well as the cultivation and classification of the herbs" (Warren et al 1982:1873).

The most serious threat to the integrity of the GPTH came from within the organization. The first National Secretary used his position to collect herbal medicines from the healers, ostensibly to experimentally verify the potency of the herbs. Some members charged that he only intended to market these herbs for personal profit. He was expelled from the Association on 18 April 1975 and barred from convening any meeting in the name of the Association.

Thus, the uncooperativeness of local officials is not wholly to blame for the lapses in the dialogue between the indigenous healers and the government representatives. The turmoil and confusion engendered by the expulsion of the National Secretary and a change of the word "healing" to "healers" in the name of the Association fuelled accusations of "fraud" by discontent practitioners. Some disputants secured the stamps and documents of the "Healing" Association and claimed to be the legitimate organization. Allegations that the former National Secretary was ultimately behind this rival group have not been substantiated, but one of his former colleagues was arrested in Techiman, Brong-Ahafo, for obtaining money from healers in the small villages. Although the case was quickly resolved, communication difficulties within Ghana make it nearly impossible to trace and discredit the splinter group. Obviously, this is a matter of some consternation to governmental representatives seeking to strengthen the bonds between indigenous and Western medicine (Warren 1989:1876).

The association is more successful in some parts of Ghana than others, with model training programs still operative in two provinces.

The Sierra Leone model: SLENTHA[11]

The Sierra Leone Traditional Healers Association (SLENTHA)[12] was launched officially in 1992. Although there had been various other loosely knit groups of healers, this is the first attempt at a national organisation. It is centred in Freetown, the capital city. There are over two hundred members listed and over 2000 claimed, but because of the continuing civil war, all activities are centred in Freetown. The momentum for the association comes from a small committed group of biomedically trained professionals and healers, not from government. The Director General is a Russian-trained medical doctor who practices a wide range of biomedical and alternative healing techniques.

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[11] The dynamics of this organisation will be examined in detail in Chapter III.

[12] This model will be discussed extensively later in the thesis. It is useful to consider the model briefly here in comparison to the other three professional associations.

There is a monthly membership fee but this is not consistently imposed. The association is taking over the role of registration of healers, an activity previously practised by the city and town councils throughout the country.

The association has a number of stated purposes such as the establishment of a clinic, herbal farm and pharmacy. None of these have been realised as yet. The weekly meetings of SLENTHA are important social occasions for those who attended regularly. They all perceive their membership as prestigious, and some have placed signs above their clinics advertising that they are members of SLENTHA. Membership is thought to increase legitimacy and credibility to the patients, thus leading to an increase in income.

There is no mention of traditional healing in the National Health Action Plan (Republic of Sierra Leone Department of Health and Social Services 1994), except for inclusion of traditional birth attendants in the section on maternal and child care. Nevertheless the government has informally acknowledged the association of traditional healers and the role that traditional healers play. The Secretary of State for Health and Social Services, Lt. Col. Dr. Akim Gibril, gave the opening address at a symposium on traditional healing in February 1993. He has publicly spoken about traditional healing on several occasions. Although there has been no tangible support for the association as yet, the government appears to be watching the development of the association very closely and offering passive support.

The Zaire model for macrolevel collaboration

Yoder has developed a comprehensive model for collaboration in Zaire. Its strength is that it is directed towards serving the patients' perspective. The model is based on thorough knowledge of the range of healing options in the pluralistic setting of Kahemba among the Cokwe people. Having acknowledged the pluralism, and indeed described it, Yoder returns to the dualistic model as a useful tool in assessing the practitioners' perspective:

> ...by treating them as part of two separate medical systems, one can better evaluate the activities of biomedical and Cokwe practitioners and discuss the possibilities of cooperation among them. The two types of practitioners differ dramatically in their assumptions about the definition and causes of illness, in what they consider relevant to the diagnosis and treatment of illness, and in how the meaning of illness episodes should be interpreted. [Yoder 1982a:1853]

He reviews the strengths of biomedicine in this region: the first is the transferability of biomedical knowledge brought by personnel from their experience elsewhere; the second is "the access to powerful drugs with standardized dosages" (1982:1854); the third is the possibility of surgical intervention.

The strengths of traditional healers in this region of Zaire, according to Yoder, are: first, their accessibility to all because of their distribution in all the villages; second is the involvement of the kin group in "diagnosis, treatment, and interpretation of meaning of the illness along with the healer" (1982a:1854); third, the emphasis on patient satisfaction which, if not heeded, means that the healer will not attract more patients.

Yoder than considers the weaknesses of both medical systems: for biomedicine they are its lack of accessibility, the fact that patients are treated in isolation, that patient satisfaction is not a driving force, and that the meaning of an illness is not addressed. For traditional medicine the weaknesses are: the fact that the causes of illness as identified are not easily verified; that the healers have few diagnostic techniques; the uneven quality of training; and the related issue, the uneven quality of treatment.

Yoder suggests that once these complementary strengths and weaknesses are considered, there is the possibility of a good fit between the two systems, which will work to the advantage of the patients.

> [Cokwe] patients are quick to use dispensary services for treatment of common symptoms of illness if the dispensary is near, they use hospital services for labor and delivery, but cases of chronic illness are taken to Cokwe practitioners. In addition, cases that may require surgery (hernias, hunting accidents) and fractures are most often taken to the hospital. Cases of severe behavioral disorders (epilepsy, mental illness) are treated by Cokwe healers.
>
> This phenomenon of 'dual use' of medical resources provides a basis for efforts to promote cooperation between biomedical and Cokwe practitioners. [1982a:1855]

Yoder's model for cooperation has three stages. The first stage establishes a research base. It has two parts, a survey of patterns of patient use of services, and a study of the case loads of some of the various practitioners including those on the margins of the dualistic model--the independent nurses, dispensers. The second stage involves biomedical and traditional practitioners in observing the clinical practices of the alternative system. Stage three involves organised discussion sessions to bring the groups together.

Yoder notes that the chief weakness of his model is the lack of incentive for the biomedical practitioners to participate. He feels that the most successful enticement is likely to be the potential for increased referrals.

There are several flaws in Yoder's model: the first is the fact that the patients don't need an increase in cooperation--they manage well with the range of choices that exist. Accessibility of the surgical alternative is not going to be changed by a program of cooperation. Second, the advantage that he offers is the increased referrals for biomedical doctors. My experience in developing countries indicates that doctors in rural areas have plenty of work to do already and that this would not be a strong motivation. The patients who would be referred would be predominantly from a rural area, and unlikely to be a significant source of increased income. Finally, the time involved in actually observing other practitioners may be problematic. Some biomedical doctors may be willing to have the healers observe their clinical work for a while, but extended teaching sessions are time consuming, and not particularly attractive to busy biomedical doctors. Some of them, in turn, may visit a traditional healer's clinic once or twice, but the repeated visits and discussions that are required to establish a working understanding of the other system are unlikely to take place.

Conclusion

There are a number of conclusions that can be drawn from the above discussion. First of all, dualism, though a useful framework for discussion of collaboration at the institutional and academic levels, is a Western construct which has influenced the collection of data and research design in the field of medical anthropology. This is borne out by a review of the range and individual variety of traditional healers' skills. The many classification systems which occur in the literature offer useful approaches to traditional healing knowledge, but remain constructs which fall short of reflecting the true complexity of the knowledge of most traditional healers.

Second, the concept of collaboration is difficult to define until it is viewed from the perspective of the patients, at which point it is already a reality. Nevertheless, since the World Health initiative is currently being expressed in part as a search for collaborative strategies, projects will continue to appear. Thus far, the most pragmatic and focused approaches enjoy the most success, while projects designed with far-reaching objectives at the policy level rarely become sustainable realities (Pillsbury 1982).

Third, it is clear that motivation of the biomedical personnel is the weakest link in discussions of institutional collaboration. Green suggests many reasons why biomedical practitioners may be reluctant to enter into collaborative arrangements such as "professional elitism and status competition, ...misunderstanding about the nature of traditional health beliefs and practices, and a genuine concern that indigenous practitioners practice in ways that may be harmful to patients" (1982:1127). Traditional healers are anxious to improve their credibility (at least in urban settings), their knowledge base and their income. Biomedical doctors already have ascribed credibility, have no reason other than personal interest to learn about traditional healing, and will not be rewarded financially in a manner sufficient to provide a strong enough motivation. Leslie (1980) argues that health professionals are the major source of resistance to planning for the rational utilisation of alternative models of healing. Joint initiatives with traditional healers at the institutional level are generally integrative rather than collaborative in nature. Associations of traditional healers, serving in some cases as vehicles for formal professionalisation, do not work well as partners in collaborative ventures to date. Institutional collaboration between government and healers' associations has been imposed, but at best the results are inconclusive.

The work of Yoder (1982a and b), Slikkeveer (1982), Bibeau (1982) and many others establishes the *de facto* understanding of the plural healing continuum from the patient's perspective. Green (1980) and others have documented incidents where collaboration has worked on a local level, usually on a personal basis, with one or more doctors referring patients to reputable healers, and vice versa. The motivation for collaboration on the basis of shared economic gain, which arises from my research, will be explored as an alternative strategy in the following chapters.

CHAPTER II

SETTING, METHODS AND THE RESEARCH DESIGN

Introduction

Research was conducted from 3 January to 17 December, 1994, in two locations, using a variety of techniques drawn from several fields (Bernard 1988). Investigation of indigenous healing knowledge proved to be very complex in an economically disadvantaged country engaged in a civil war. The research plan had to be altered in the third month of the twelve-month field-work period when the first site, the rural town of Kenema, was attacked by rebels. Evacuation from Kenema created wider opportunities to study healers in the Freetown area, to examine the dynamics of SLENTHA, the Sierra Leone Traditional Healers' Association, and to determine the nature of the national health care delivery system and the potential for collaboration between traditional healers and biomedical professionals. I also visited the homes and clinics where many of the healers practice, and I accompanied two of my key informants into the bush to collect medicinal bark.

The first section of this chapter describes Sierra Leone, the West African country where the research took place. The second section includes the methodological approaches and techniques for the data collection.

Sierra Leone: The setting

Sierra Leone is a small republic in West Africa, approximately the size of Austria. The southern border of the country is on the Atlantic seacoast, seven degrees from the equator. There are two distinct seasons, the dry season which lasts from approximately December until May, and the wet season which lasts from June to November. The population is 4.5 million, with seventeen linguistic groups. The country has rich resources in industrial diamonds and other minerals such as rutile and gold. It is primarily an agricultural economy, but in recent years Sierra Leone has become a net importer of many commodities which were formerly self-sustaining, including rice.

This research took place in two very different sites in Sierra Leone. The sites were Freetown and Kenema. The capital city of Freetown is an old port city, incorporated in 1893. It served as a centre for precolonial trade in timber, palm oil and other tropical products, and for slaves. Sierra Leone was a British colony until 1961 (Abraham 1978; Asad 1973), when it became an independent republic. For most of the colonial period (1787-1961) the British authorities governed from the Colony of the Western Region, a small area around Freetown, leaving the larger area as a Protectorate under patterns of traditional leadership. The country has a population of various ethnic groups, many of whom, like the Mende, Fula and Mandingo, have migrated south over the centuries from the lands to the north. The Krio people of Freetown claim descent from freed slaves who were returned to Africa in the late 19th century. Although they now constitute a small minority, they still occupy many leadership positions because they were the first beneficiaries of the missionary educational institutions.

After independence the country experienced a brief period of economic expansion, and then, under the rule of the All People's Congress Party (APC), suffered a steady decline. The health care system was profoundly affected to the extent that government hospitals face severe shortages of drugs and equipment. The once-free medical service is now provided at prohibitive fees under appalling conditions.

The social, political and economic decline in Sierra Leone has been attributed to the uncontrolled corruption of a long-standing one-party regime, but the world recession and the civil wars in surrounding nations also contributed to the disintegration of the infrastructure.

This study of traditional healing cannot be presented without addressing the interlocking of the war with the lives of the people involved in the study, and the life of the researcher.

The current fighting in Sierra Leone began in the late 1980s as a spill-over from the insurrection led by Charles Taylor in neighbouring Liberia (Beinen 1987; Harbeson 1987). Foday Sankoh emerged as the leader of the rebels in Sierra

Leone. Their objective was the removal of the APC government which had been in place for some twenty-three years. In April, 1992, after a bloodless revolution, the National Provisional Ruling Council (NPRC) took control. Despite the achievement of their stated goals, Foday Sankoh and his rebels continued to fight the government forces in the Eastern and Southern Provinces. In the past year the fighting has intensified at the same time as the perpetrators have factionalised. The purpose of the fighting is unclear and unfocused. The rebels lack unity and leadership (Richards 1994; Ayoade 1988). It is now generally conceded that the rebels are disenchanted soldiers, and that the problem is a combination of poverty (Magbaily 1988), lack of leadership and opportunistic behaviour of the rebels (Richards 1993a and b). As the research period passed the fighting spread to the Northern Province as well. Villages were being burned, relief food shipments looted and whole regions emptied of residents. The situation has become a chronic state of low-grade internal warfare, and has displaced[13] over 1.5 million people to date.

Although the conflict continues, some progress has been made under the present regime (Zack-Williams 1993). The roads are the most obvious improvement. A new highway has been constructed inland to the east. Several roads within Freetown have been rebuilt, and electric power, although intermittent, has been partially restored to the city. Sewage and drainage systems are being repaired. An effort has been made to improve the general appearance of the city with murals, military statues, and gardens. The main hospital in the capital has been improved, although supply shortages and lack of reliable electricity mean that service is still at a very low level. These advances are balanced by continued economic decay, corruption among the current government officials, continued corruption among the civil servants who were not replaced by the new regime, and mismanagement of aid grants and emergency supplies (Kaplan 1994).

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[13] People whose lives have been disrupted by the war are classified either as internally displaced if they have remained within the borders of Sierra Leone, or refugees if they have crossed the borders into neighbouring Guinea. The total of both groups is above 1.5 million, one-third of the population of the country.

The economic condition is reflected in the level of salaries at all levels. Even highly placed civil servants are paid only Le 30,000 to 40,000 per month, or Cdn $60-85 per month. It is not possible to support a family on such an income, and so the incentive for multiple employment, bribes, pilfering, illegal diamond mining, and many other entrepreneurial ventures is strong.

Almost everyone in the country has developed strategies for increasing monthly income. This is generally referred to as "business" or petty trading. It means everything from cooking extra food and selling it in offices or in the neighbourhood, to growing a few extra vegetables in the family garden and selling them, to making soap, cookies or gara[14] for sale, to buying small quantities of kerosene, sugar or wood and reselling them in the street. There are many such strategies pursued by even small children of five years or so. Begging is also such a strategy, and the number of beggars increases daily as the three-year-old civil war continues to deepen the economic instability and weaken the morale of a long-suffering people. Some of the more affluent are involved in illicit diamond and gold mining and commodity and land speculation.

The corrupt allocation of resources at all levels of the infrastructure combined with the destabilising effect of the opportunistic looting by rebels/soldiers forces the continuing short term survival strategies.[15] This is affecting the policies of international donors, who are pulling back and redefining their priorities, including health care funding.

Since income is erratic for everyone in Sierra Leone, long-range planning is impossible for most individuals and families. Most people can only plan one day at a time. The future is unknown and uncontrollable, a situation reflected in the pervasive fatalism of both the Christian and Muslim church ideologies in the country. The patients and health care personnel included in this study reflect this picture consistently.

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[14] Imported cotton cloth dyed using traditional techniques and patterns.

[15] In a pragmatic piece of legislation the US Senate Committee on Foreign Relations passed The African Conflict Resolution Act in October 1994, acknowledging that demobilisation of the military must take precedence over all other aid/development efforts in Africa.

Freetown

Nonetheless Freetown, the capital, retains a certain sense of continuity. The city is a patchwork of connecting villages whose names recall their tribal/colonial history: Congotown, Krootown, Kingtom, Foulahtown, Madongotown, Kissy; Murraytown, Wilberforce, Allentown. The neoclassical Law Courts Building, the City Hotel and many decaying stately colonial homes coexist with the two-story wooden Krio houses and the less imposing contemporary office buildings. The Chinese have added an unexpected flourish to the architecture of the city with the large scale of the National Stadium and the curves and spirals of the Army Headquarters Building. Freetown is on a peninsula in the Western area--the former British Colony.[16] The natural harbour is the third deepest in the world, but now most of the big ships pass silently across the horizon without stopping. There is little trade with Sierra Leone these days.

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[16] The Three Provinces were known as The Protectorate.

The effect of the war is less obvious in Freetown although many families have extra relatives in their homes, displaced survivors from the burned villages of the war zone. Because of government suppression of the media, there is rarely any news of the war available in Freetown by radio, television or in the newspapers. Consequently the rumour mill has disproportionate power. On the morning September 13, 1994, there was an explosion in Sussex, a village just west of the city. The rumour of an attack and coup spread within an hour to the city, and along the main street of Freetown. I did not hear the rumour until I had walked the length of the street to attend a meeting. I was puzzled because all the stores were closed and locked, and there were no people or cars on the street. When I reached the meeting we listened to an announcer's voice on the one radio station reassuring us that there was nothing to worry about, but providing no information as to what the source of the rumour was. Soon the phone rang and we were told that some fishermen had set off some dynamite at the Sussex dock. The city did not resume normal operation until the following day. Most shops remained closed. There is now a law which provides for prosecution of those found passing unsubstantiated rumours.

Kenema

The initial research site is the rural town of Kenema in the Eastern Province. Kenema is 192 miles by road from Freetown. The national air service of the seventies has long since been discontinued, and the narrow gauge rail line torn up and sold for scrap. The road to the east is presently being improved by an Italian construction firm. The Eastern Province is rich in agricultural produce and diamonds. Kenema is the trade and industrial centre of the Eastern Province. Many of the major businesses are run by Lebanese merchants who also trade in diamonds from their shops. The population of Kenema is approximately 20,000 in normal times but it is estimated that there were an additional 40-60,000 displaced persons in the town. The majority of the people are Mende, but there are people of many other ethnic groups. It is very common for families to have as many as twenty or thirty extra relatives staying in their homes: relatives displaced from other parts of the province. Although the Red Cross has a warehouse in town, the relief supplies are inconsistent, and the displaced people do not receive adequate assistance with either food or clothing.

The Eastern Province has been severely affected by the last three years of warfare. Many towns and villages have been attacked, looted and burned by the rebels. Kenema remains secure, although the main road to Freetown has been closed since June, 1994. Because Kenema is somewhat isolated, however, an air of anxiety pervades the town. Many of the shops carry only a skeleton stock, having sent their more valuable goods to storage in Freetown. During the month of March, 1994, during this research period, the risk of attack was perceived to be so high that many prominent citizens sent their wives and families to Freetown for safety.

After a particularly brutal attack in the nearby town of Panguma in March, 1994, when a Dutch doctor, his wife and three-year-old child, and a priest were brutally killed while trying to leave the hospital compound, my friends and associates at the hospital pressured me to leave. The trip to Freetown was made March 14th in convoy with an army escort because of the frequent ambushes on the highway. The ECOMOG--combined peace-keeping forces of West Africa--provided the escort vehicles. The trip was relatively uneventful, although the escort fired repeatedly into the bush at the points at which previous incidents had occurred. The morning after our departure the regional leader of the armed forces was ambushed on the same road, and several of his entourage killed or wounded. I returned to Kenema once after in early June for two days when the road was briefly considered safe. It has been closed since the 6th of June and I have not been back.

A consequence of the war that has influenced my research is that many traditional healers are among the displaced people now resident in Kenema. Thus the research base was broader than it might have been.

Overlying every aspect of this study is the low-grade conflict, the kind of war that is endemic in Africa. War may be too strong a word for the haphazard skirmishes which usually involve twenty to fifty people who attack a village, a car passing on the main road, trucks carrying relief supplies and occasionally the daily government bus which moves in an armed convoy. The attacks are sudden, and the object is looting, although there may be one or more victims, innocent individuals who happen to be in the wrong place at the wrong time. It is the senselessness and unpredictability of these attacks that has led to the anxiety which pervades the towns and villages in the provinces. Sometimes this ambience recedes, but it never completely disappears. And sometimes the anxiety becomes acute for a few days, always triggered by news (often false rumours) of another attack.

Communication in this small country does not exist at the village level. Families are split, sometimes for many years, as they flee from an attack into the surrounding bush. Children and older people disappear. Perhaps they will be found in the months or years to come in one of the many camps for the displaced people and refugees. Or perhaps an acquaintance will bring word of a relative who was seen in a village behind the rebel lines. This country is only 250 miles wide at its broadest point, but the cost of transport from one part to another is several thousand leones, well beyond the reach of most villagers, even to search for their family members.

It may appear that the political situation in Sierra Leone, with its continuing civil strife and consequent socio-economic instability is an inappropriate site for research. Many countries in Africa, Latin America and elsewhere, however, are experiencing similar static civil war conditions (Kaplan 1994). Waiting "till the war ends" is to put off many important projects indefinitely. Thus it is more realistic to accept the present circumstances as a continuing reality and work within these constraints. Secondly, the continuing civil strife has taxed the economy of Sierra Leone to such an extent that health care services are drastically underfunded. The biomedical system cannot be sustained, even with the low cost of the network of community-level clinics and traditional birth attendants. These facilities are under-supplied, and many are operating in an inadequate or even dangerous fashion, while others have ceased to function altogether. The public sector health care facilities have slid into the private sector by default.

The National Health Action Plan, launched in February of 1994 by the Secretary of State for Health and Social Services, does not mention traditional healing. It was prepared by an ad hoc committee of biomedical practitioners at a workshop sponsored by WHO. Although the Plan refers to "...a new focus on the development of preventive services while simultaneously strengthening the existing secondary and tertiary sectors (Gibril 1993:iii), the document remains largely theoretical. The political and economic instability of the past two decades has eroded the health care system to the point that there is little national direction. The recent rebel incursions have rendered such coordination impossible. Change, development and restructuring cannot take place in such a setting.

Rehabilitation will require

> ...re-establishing a public health system, bringing hospitals back into the public sector, providing [adequate] treatment for the poor, for lepers and those with tuberculosis, and ensuring a place again for preventive medicine, a service never provided for in the private sector. Support for the workforce for such a return to a public health service requires delicate negotiations covering matters such as pay prospects, job motivation, working conditions and equipment. [Jean 1993:142].

The task of rehabilitating the national health system cannot yet begin, and will be very costly once it does, requiring fundamental social change. Thus the potential to increase health care coverage by including traditional healers in the national health care system is one of the few cost-effective alternatives available.

The Gender Issue: A Brief Confessional Tale

Another issue related to this research setting is gender--that of the researcher in the context of patterns of gender relationships in the field. In his book, *Tales from the Field,* John Van Maanen (1988) describes the "confessional tale" as one of three styles that anthropologists use in describing their field experiences. This style is a useful device for acknowledging that the characteristics of each individual researcher affect the realm of data available. For example, gender, age, image of economic status, religion, ethnic origin and marital status are a few of the factors which can prevent or enhance access to and participation in various domains of cultural knowledge. Awareness of these factors increases effectiveness, and decreases probability of social errors and offensive behaviour. I will adopt the Van Maanen's confessional style for the following discussion.

Before leaving for my field work I read extensively about the field experiences of others, both men and women. I am grateful to those who have gone before me because I was well-prepared for many new interpersonal situations. I recognised and coped with power inequities between the people I worked with and myself, and within their groups. I recognised the complexity and power asymmetry (Razavi 1993:154) of being white in a post-colonial culture. I recognised the fear that some of the healers felt that I might report them for not being licensed, or that I would betray their secrets.

I was not, however, prepared for the difficulties inherent in being a female in that culture. (My previous experience in 1971-72 had been as a nurse in a very structured setting.) While I was in the field Devereux and Hoddington (1993) brought out an edited collection of articles which touches on the issues of age and gender. It is a valuable contribution but misses some of the more personal issues that I raise briefly and rather bluntly here. I am writing this section, therefore, so that other female students might be better prepared than I was. First of all, there is the issue of romance. Despite my age, fifty-three, and my white hair, I was considered sexually desirable by a number of men. Flattering though this was so many years after I had dismissed this self-perception from the realm of reality, it also caused many problems. The reasons for this were complex, relating not only to my appearance and demeanour, but to the perceived desirability of a white woman by some African men[17]. There were interpersonal tensions when this motive was high on the list of the occasional informant. There were also periodic rumours about my leisure time which, while intriguing, were neither truthful nor complimentary in either culture.

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[17] It is believed by many African men that white women are more sexually responsive than African women who have been circumcised.

Secondly, there is the issue of loneliness, the absence of friends, both female and male, who know and accept your history, your interests, your quirks and predilections. It takes time to make new friends, particularly in a cross-cultural setting. I especially missed the company of women my age, since in Sierra Leone most of the women in their fifties are grandmothers who remain at home. There are very few professional women. One must be creative in addressing these needs. I would go and sit with the older women at the Bundu Society house in Kenema where, although I did not speak Mende, there was a feeling of warmth and welcome.

Third, there is the issue of being female in a strongly male dominant culture. The most striking expression of this was my husband's brief visit to the field. He is an engineer, and not particularly interested in traditional healing. While he was visiting I continued to conduct interviews with healers in my apartment. When he was present the ambience changed noticeably. The healers directed all comments and questions to my husband. He was treated with decided deference, and was even asked by two healers to intervene in the affairs of SLENTHA, the traditional healers' association. There was an assumption on the part of several male healers that I was working under my husband's direction. Many others assumed that everything I did was subject to his approval, which is consistent with the ideal if not the actual Sierra Leonean model. I was at some pains to explain to them that this was inappropriate. Explanations were fruitless, as I was then seen as an insubordinate wife, further weakening my crumbling status. Our solution was for my husband to return to Canada forthwith, rather than stay for a month or two. Within two weeks of his departure I was able to rebuild the rapport I had achieved earlier with most of the men with whom I was working.

Two months later when my advisor, also a male, came to visit for two weeks a similar attitude reappeared in some of my key informants, creating the occasional awkward situation. The assumption was that my advisor could influence me to help them find sources of funding, or to serve them in other ways which were inconsistent with my research agenda. I was more prepared this time, and the repercussions were minimal. Such situations should not be surprising in a male-dominant culture where organisational hierarchy is very important and status is ascribed as often as it is achieved. As a woman alone, once again, my professional status was quickly re-established and rarely questioned.

Since my return to Canada I have spoken to several other women, none of whom felt that they were prepared for this facet of field work. We just muddle through, laughing when we can, being angry now and then, and trying not to let our personal feelings "spoil" our research.

However, these events are very much a part of the research experience and are as worthy of consideration as other social and interpersonal factors. Just as we consider the role of the white anthropologist in a post-colonial country, we can save considerable pain and embarrassment if we also consider the role of the female anthropologist in a male-dominant culture. Questions such as should my husband or advisor visit, what are the pros and cons of taking a child along (and at what age), and what pattern of comportment is best adopted in potentially sensuous situations, can only be answered very personally. An open discussion of the experience of others would have helped me and my twenty-six year old daughter who served as my research assistant for the first six months.

This is not to say that there are not some advantages to being a fifty-three year old white female researcher. My white hair seemed to engender respect from a variety of people, including young soldiers at military check-points.

Techniques and Methodology for Data Collection

I distinguish between these two terms in that techniques are how the data is gathered, while methodology is the strategy behind the selection of particular techniques. For example, I chose to attend SLENTHA meetings, visit homes and clinics of healers and accompany them as they collected medicinal plants. These techniques all fall under the methodological heading of participant observation. Serious discussions with doctors and other biomedical professionals, and interviews with healers fall under the umbrella of open-ended or unstructured interviews. Some of these, when extended or oft-repeated, become in-depth key-informant interviews. There were also many meetings, symposia, ceremonies and field visits where I did not actively participate, during which I was conducting direct observation (Bernard 1988). Some of the people with whom I worked were colleagues with their own motivation for collaborating with me on this research. They were clearly participants, and this was an experiment in participant observation research.

The Ethnographic Interviews

The Healer's Interviews: Kenema and Freetown

I conducted 72 interviews with 49 healers. Fifteen of these interviews were with 15 healers in Kenema, and there were 57 interviews with 34 healers in Freetown. The interviews were conducted over a period of six months, January to July of 1994. In addition I supervised and analysed 94 more interviews in seven hospitals in the Western Area and Southern Province. Of these, 73 were with patients and the rest were with biomedical personnel.

During the interviews I had an index card in front of me with some key words on it to remind me to collect certain key data points such as origin of healing knowledge, and other points which I wanted to be able to compare and collate later.

I taped all interviews on a small microcassette recorder, and the interviews were later transcribed. During the interviews I made brief notes to guide the interview back on track if it wandered too far afield. In cases where the conversation went off in an interesting direction, my notes would simply say where we had been derailed from the healing track so that I could get us back there later. These conversational diversions were almost always rich sources of cultural data. Such digressions included information about the escape of several healers from the rebels, about tribal migrations and clan history, and other stories not directly related to my research.

Language

The interviews were conducted in Mende, Krio and English. I was soon able to ask my own questions in Krio, but it was some time before I could fully understand the answers. Both the Krio and the Mende interviews were translated from the tapes and transcribed into the computer. In some of the earliest interviews in both languages, and in all Mende interviews, I had an interpreter translate into English throughout the interview. Special care was taken during the actual translation from microcassette tape to the database to ensure that the words used were true to what the informant actually said, rather than relying only on the interpreter's summary translation during the interview. This process served as a double check for validity of translation as well.

One of the dangers of working in a para-medical field, and also working across the boundaries of traditional and Western medicine is the temptation to use biomedical terminology when discussing traditional healing. For example, it is tempting to discuss fractures instead of bone work, or tuberculosis instead of dry cough. Wherever possible, such transpositions have been avoided in transcriptions and discussion.

The Selection Process

In the first research location, the town of Kenema, my personal connections from my previous work as a nurse in 1972 established my credibility. Many of those who participated found the process useful and/or enjoyable, and referred me to others, or sent their colleagues to see me. The interviews in Freetown evolved similarly, at first facilitated by the director of SLENTHA, then by other healers and friends.

This is hardly a random sample. Qualitative research is concerned with groups such as this self-selected and specially chosen group because of their ability to provide the required data. Had I wanted to define a random sample, this would have been impossible, since there are no comprehensive lists of healers in the country. Research was, however, comprehensive in that I interviewed every one that I encountered who expressed interest and permission.

Interview Setting

The first set of interviews, those conducted in the town of Kenema, were conducted both in the homes of the healers and in my apartment. I worked at the 40-bed hospital in town for a couple of hours every day, assisting with renovations and re-establishment of administrative systems, and had an office there (my former office as Sister-in-Charge of the hospital in 1972). I was warned by the Paramount Chief of the Kenema Chiefdom that the healers might feel intimidated about coming to my office in the clinic or to my apartment (8F)[18]. After a few sessions in their homes, however, I found that there was sometimes so much interference that it was difficult to sustain the thread of the interview conversation. Many people from within the healer's household and neighbourhood would gather around, including the children and babies. When this appeared to be a problem I would change the first interview into a courtesy call and make a subsequent appointment for an interview at my apartment. My experience with hosting the healers in my apartment was that the environment was controlled, there were few distractions, and the healers seemed genuinely pleased to be invited into my home and served a cold drink. (Bitter lemon, an English type of soda pop, was the favourite.)

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[18] Coded reference to interview data.

The second block of interviews, in Freetown, were also held at various sites: healers' homes, my apartment, a market stall and healer's clinics. Flexibility as a strategy for selecting the sites seemed to work well. I made a serious effort to fit the interviews into the schedules of the healers, many of whom had a variety of professional and family responsibilities.

Compensation

I chose to compensate the healers with a token payment at the end of each interview, for several reasons. First, it is appropriate behaviour to offer a gift of food and money to a chief when he or she visits your home, and several of my informants were chiefs. Secondly, the economy was such that everyone I met was affected by economic problems related to the war and economic stagnation, and appreciated any assistance they could get. Finally, I felt that it was just to pay people for their time. For most I gave them 500 leones, the cost of a daily meal of rice. For those who travelled from a distance to meet with me, I also paid transport costs.

On occasion my compensation pattern caused a problem, in that healers would then expect gifts each time they came, or come back several times after the interview to request money. This happened with only three, and so I am convinced that the compensation strategy was appropriate.

Cultural Relativism

There is a danger in medical anthropology, just as in what Escobar (1991) calls "development anthropology" that research should be directional; that is, conducted with a view to improvement of health care. The commitment to making a contribution is often characteristic of applied research but such contributions are often superficial. Unless this commitment goes hand in hand with a serious and deep understanding and implementation of meaningful community participation, the end result may be yet another project which makes little or no long term contribution to the community, and may, indeed, have created unrealistic expectations and dependencies about hospital and clinic-based health care. This warning about development as a unidirectional process arising from Western values of progress leads to a brief consideration of cultural relativism as the alternative.

A pragmatic application of cultural relativism (Lemaire 1991), the view that indigenous knowledge exists in its own right, and in its own context, is a useful approach at the commencement of a research project in traditional healing methods in West Africa (Gellner 1985). Suspending judgement temporarily is a necessary step to establishing trust with healers. All of the healers asked why this research was being done, some with more diplomacy than others. Some wanted to know why I felt I had the right to take their time, and what use it would be to them. Such justification was an essential component of this research.

Confidentiality

This is a complicated issue, and my strategy changed over time. At first I tried to guarantee confidentiality, but as time went on I realised that this concept was silly to the informants. If I didn't want to tell anyone, why was I asking for the information? Further, most of them wanted to tell me about their work and wanted me to tell others. A prime motivation for the interviews was the fact that an educated white person was interested in their work, enhancing the potential for becoming better known, more credible and attracting more patients as a result of the interview process.

Very quickly I realised also that I did not require any secret information. I did not want the recipes for herbal remedies, nor were the rites of the secret societies germane to the thrust of my research. My experience was in keeping with Ken Wilson's comments:

> Researchers need to think hard about when and how to maintain confidentiality and anonymity. Confidentiality--not revealing facts elicited through field research--seems necessary only in particular situations. In my research, I make no general promises of confidentiality to my informants--on the contrary, I emphasise that I want people to tell me things precisely so that they can be made known. However, I generally avoid providing unnecessary details if there is any reason to suppose this could be used against the informant or population. [Wilson 1993:186]

The only time where confidentiality was important was when healers were concerned that I might report them to the authorities for not being registered, or for having a lapsed registration. In such cases I reassured them as well as I could, and in no case did this seem to affect the quality of the data collected in the interview.

After the first few interviews I stopped emphasising confidentiality, and instead introduced the interviews as an opportunity for the healers to contribute to the process of making their skills known to the national organisation and to the Ministry of Health. This motivation seemed less important to most of the Kenema healers (than to Freetown healers) who because of distance and lack of communications, were unlikely to be affected by either body.

My decision flies in the face of traditional anthropological method. Van Willigen insists that "it is absolutely necessary to maintain the anonymity of our research subjects" (1986:49). In handling my data I have chosen to use only the interview code when referring to the data. I have made it clear that access to the interview data itself will be restricted, but that the results will be made available to the government and to the healers' association as well as to the university.

The patient-centred research in the tuberculosis study was much more sensitive than the healers' interviews, and in most cases I have preserved the tuberculosis patients and staff members' anonymity. In a small country like Sierra Leone these people are easily traced, and jobs and reputations can be threatened by an open and honest comment.

Interpreters

My experience during the first few weeks in Freetown was consistent with Hammersley and Atkinson's warning:

> Even the most friendly and co-operative of gatekeepers will shape the conduct and development of the research.... The fieldworker may well find him- or herself involved in varieties of 'patron-client' relationship with sponsors, and in so doing find influence exerted in quite unforeseen ways. [1983:73]

The "gatekeeper" who facilitated and translated the first few interviews in Freetown, Dr. Taylor-Lewis, a medical doctor, had his own agenda in terms of me obtaining funding for SLENTHA. I realised that he was also translating the healers' words into biomedical terms. My initial effort to establish direct relationships with healers was tactfully but effectively blocked. Consequently I quickly established my own network for interviews, learned Krio, the most common language in the country, and also found another colleague, Hamidu Jalloh, to serve as translator and transcriber of some of the interviews.

I owe a great debt to my two hard-working colleagues, one in Kenema and the other in Freetown. Not only did they do their job of interpreting during the interviews, but later had to reinterpret and transcribe each tape. This was very time-consuming and often boring, but there was never a complaint. The Freetown person came into my life as my Krio teacher, and became interpreter, translator, transcriber, cultural broker and later was trained to conduct ethnographic interviews for a subsequent study (Kaufert 1984). As he transcribed the interview tapes, he added personal comments and interpretations, supplying information about healing techniques and belief systems that I could not have known, and filling in the tapestry of culture. An example is his explanation of the cloth fetish tied on a stick in a garden to protect the harvest and curse interlopers. There were many more times when I would find expository notes included in Hamidu's written transcriptions from the tapes, or when he would explain concepts from the tapes to me during our coffee breaks. Hamidu is a graduate of the University of Sierra Leone, and was experienced in cross-cultural orientation, having worked with American Peace Corps and British volunteers. His knowledge of the various ethnic groups of Sierra Leone was an invaluable asset.

Key Informant Interviews

I have treated the data from these interviews with the techniques of thematic analysis. I was sometimes able to have the key-informant review my transcribed interview notes and check for misinterpretation. This process enhanced our relationship, and induced a sense of true participation, as each of these people was involved with the healers' association in one way or another.

The Tuberculosis Project Interviews

By September I had become reasonably visible in the health circles of Sierra Leone, and was approached by the National Leprosy and Tuberculosis Control Programme (NLTCP) to design a practical research project. Since the topic was complementary to my research question and would further enhance my understanding of the interaction between the traditional and biomedical systems, I accepted. I trained my colleague in the art of open-ended interviews and over a two-month period he conducted 94 interviews in seven clinical settings in the country. (Twenty of these were with biomedically trained staff, primarily nurses.) The objective of the study was to describe the actual informal costs, above and beyond the stipulated fees, of receiving treatment for tuberculosis. In the guidelines for the interviews we included questions about traditional healing, incidents of biomedical/traditional healer referral and collaboration.

This research revealed a hidden dimension of the treatment of tuberculosis in the country, and may have far reaching effects in policy definition for the Ministry of Health. We discovered that the cost of being treated for tuberculosis was minimal once the patient had entered the formal TB treatment program. The financial burden of TB was most onerous in the pre-treatment phase--the months and years of treatment by a variety of healers, including medical doctors and traditional healers.

These interviews provided another perspective on my research topic, traditional healing--that of the patient. Thus far I had experienced the views of the healers through my interviews and the views of the biomedical practitioners through my work at the Nongowa Clinic. This study gave me a valuable opportunity to balance the equation with those who receive the services of the practitioners.

In summary, the bulk of the interview data for this study was drawn from three interview situations, the healers' interviews, the key-informant interviews, and the tuberculosis study.

Participant Observation

Direct Observation

"In continuous monitoring, you watch a subject or group of subjects for a specific period of time, and record their behaviour as faithfully as possible" (Bernard 1988:272).

According to Bernard, this is one of the least ethically troubling methods available to the anthropologist. The research is overt, and the technique is clear to those being observed (1988:289). In related methods such as participant observation the researcher hopes that the informant will forget that this is research, and behave in a manner as close to normal as possible. This is considered by some to be mild deception. The observer creates the least distraction in highly structured activities; in less structured settings, there may be an intangible effect from the presence of the observer. Bernard calls direct observation less "friendly" than participant observation. It is much more a distanced process, involving the objectification of those being observed (Bourdieu in Jenkins 1992).

I attended every executive meeting and general meeting of the traditional healers association in Freetown from January until July of 1993: five executive meetings and fifteen general meetings. My role in most of these meetings was clearly that of a direct observer, particularly during the first few months. Although I was given a position of honour next to the director at the head table, I did not participate, but took detailed notes which were later transcribed into the computer. As time went by I became more involved, and I will discuss my role as participant below.

I attended two formal "launches", the official launch of the National Health Action Plan, and the launch of the Sickle Cell Association. These occasions provided an opportunity for me to observe the larger domain of national health care programs and to meet some of the senior officials in the health care system, including the Secretary of State for Health. He expressed interest in any recommendations which might arise from my research.

I also spent an afternoon in the bush collecting medicinal herbs with two members of SLENTHA, one of whom became a key informant. B.M.S. Turay taught me about techniques and equipment for harvesting supplies of bark and leaves. I also visited his home/clinic several times to see his techniques of drying and processing the plant materials.

Along with the executive of SLENTHA I paid two visits to the chief and healers of the village of Songo, some thirty-four miles from Freetown. The purpose of the visits was to recruit members for SLENTHA.

Participant Observation in Practice

Although Spradley (1980) considers participant observation to be a method, according to Bernard it is less a method than a strategy (Bernard 1988:150). It is certainly one of the most time-honoured methods of qualitative research. Participant Observation is the act of being in an environment in as close to "normal" conditions as it is possible for an outsider to achieve, and of observing, and later recording what is going on. This involves being familiar with the language of the population, if it is different, before embarking upon field work. Bernard points out that the idioms, inflections, and nonverbal cues, or even the jargon of a subculture in your own society, only become familiar through the process of participant observation.

In conjunction with my involvement in SLENTHA, I made two speeches during my stay in Sierra Leone. One was an address to the February 28th SLENTHA symposium, with the Secretary of State for Health also at the head table. I used this opportunity to speak of collaboration, since the Minster is a gynecologist, and several other doctors were in attendance for the opening ceremony and speeches. This opened the door to many subsequent informal discussions with them at receptions in later months. This speech was televised on national television. Portions of it were carried on radio, and reprinted in the local newspapers. It was also printed in the WHO regional newsletter.

My visibility was a key factor in my being asked to attend presentations to government along with the SLENTHA executive. I was pleased to do this, realising that they saw my presence as adding prestige. This was an ethical dilemma which I discussed with several people including the executive director, who felt that my scruples were inappropriate, and that my presence was an important factor in the success of their funding strategy.

My daughter and I also did considerable amounts of typing for the director of the organisation as a service. We typed his speeches, and a number of proposals and letters to the government. I assisted him to draft designs for a clinic, a symposium and a research project.

In the final month of my stay I was invited to address the annual convention of the Sierra Leone Medical and Dental Association. Here again I took the opportunity to speak about traditional healing and the potential for collaboration, focusing on the tuberculosis research. Despite the fact that I was the last speaker on the final Friday afternoon of the conference, the question period was extensive, and there was interest on the part of several doctors to pursue the topic of traditional healing. Several requested copies of the TB report and anything that would help them to understand more about the perspective and range of experience of their patients. This experience confirmed that the potential for collaboration on an institutional level could be pursued, but that it would be most effective on an individual basis, or with small groups with at least an initial commitment to broadening their knowledge about their patients.

CHAPTER III: DISCUSSION AND ANALYSIS OF THE DATA

Overview

Throughout this research the key themes were the issues of collaboration between biomedical and traditional practitioners and ownership of indigenous knowledge. It was my goal to explore the potential for collaboration between biomedical practitioners and traditional healers on a macrolevel, or institutional level in Sierra Leone. This was motivated by the many examples of such initiatives in the literature. I was surprised to discover that collaboration is not practical or even possible in the way that I had constructed it in my research proposal. The complexity of the motivation for institutional collaboration is only one of the many factors which influence success. I found that collaboration occurs *de facto* on a day-to-day, person-to-person level, the microlevel, and that this concept is more useful and realistic than the idealised institutional level in the context of present political circumstances in Sierra Leone.

Another factor which mitigated against promoting institutional level collaboration was the realisation that the individual experiences of the healers in my study differ greatly. There is no core body of knowledge that is traditional healing, *per se*, comparable to the identifiable formalised core of biomedical knowledge shared by all those who have been professionally trained in Western medicine

(Good and Good 1993). Furthermore, the range of knowledge within the practices of biomedical doctors is also more varied in a setting like Sierra Leone than it might be in a more ethnically and educationally uniform culture.

In Sierra Leone, although doctors are generally members of the elite, they are still culturally diverse, drawn from one or more of seventeen distinct tribal cultures (Banton 1957; Fyfe 1964; Kandeh 1992). They often go overseas for their training, returning with the cultural overlay of medical schools in Germany, Russia, the United States or England. Thus in the Sierra Leonean context both concepts, biomedicine and indigenous healing knowledge, are artificial constructs, although the common core of biomedical knowledge remains more definable.

Finally, the issue of ownership of indigenous knowledge, a major political issue in North America, is not of importance in the same way in Sierra Leone. Instead, preservation and perpetuation of indigenous healing knowledge are paramount concerns. The traditional methods of perpetuation of traditional knowledge are disrupted by the war. Economic necessity has become a prime motivation for sharing of indigenous knowledge, in hopes of a direct or indirect financial return. All healers with whom I worked were anxious to be part of a production unit marketing traditional remedies which will return a profit to them, whether it is initiated by an individual entrepreneur, through SLENTHA, or through the College of Medicine. Both of these incentives, preservation and profit, may be a result of the two decades of economic decline, or the four years of war and social disruption, or both. I do not know if the same perspective pertained in the 1970s, but I am sure that the economic incentive wasn't as immediate as it is now, nor were the opportunities for commercial development of herbal remedies as widely available as they are today.

The Data

Fifteen healers were interviewed in Kenema, a large town in the Eastern Province, before the war made the town inaccessible. Subsequently thirty-one healers were interviewed in Freetown, several of them on more than one occasion. These interviews are the data for Section I of this chapter. Beyond this, two key informants, also healers, were interviewed in more depth, and the resulting data is the base for the discussion in Section II. On a related research project ninety-four interviews were conducted in seven hospitals with tuberculosis patients and biomedical personnel. This data, discussed in Section III, balances the healers' data with the patients' perspective on traditional healing. Finally, the data collected through participant observation are discussed and analysed in Section IV.

My content analysis techniques (Patton 1990) included organising and re-reading all the original data, selecting key words and concepts and listing them with brief notes. The words were then screened and classed under more specific headings which relate to the research questions about the potential for collaboration between biomedical practitioners and traditional healers and the nature and ownership of indigenous healing knowledge in Sierra Leone. From the list of main topics I could then identify themes and categories based on the inductive approach of content analysis (Patton 1990:390). This analysis caused rephrasing of the research questions, and a shifting of emphasis which responded to the patterns revealed by the data. I was very aware of what Van Maanen termed "the interaction of method, theory and data" (1989:250). The element of surprise in research activities (Van Maanen 1988, Agar 1983), and of spontaneous discovery of new patterns (Bateson 1994), provides the excitement in the analysis process for the researcher. This flexibility is an advantage of qualitative research methods such as those employed in this study (Johnson and Sargent 1990).

SECTION I: THE TRADITIONAL HEALERS OF KENEMA AND FREETOWN

Range of Healing Skills

In Sierra Leone indigenous healing knowledge is inextricably interwoven with spirituality, with social control and with cultural values. Healing is not merely health-directed, but plays an important social role in linking the various other elements of the culture, or, more accurately perhaps, it is an integral part of every aspect of the whole culture.

Thus attempts to categorise are useful for discussion, but can be misleading if they are used to impose restrictions upon various "categories" of healers. The director of the Sierra Leone Traditional Healers Association (SLENTHA) used the following terms:

(a) Pure herbalists
(b) Pure diviners (Biblical and Quranic)
(c) Herbalist diviners
(d) Occultists or mystics [Speech Feb. 28, 1994]

Based on the interview data there are few healers who practice any of the four categories exclusively. For example, a healer in Kenema claims to cure thirty-six types of sickness including crazy people,[19] women who don't get their period, infertility, those that cannot walk, impotence, witchcraft caused illness, toothache, piles, fast heart beat, bone ache, boils, constipation, and worms (1K). Another heals eye problems, treats leprosy, delivers babies, counteracts witchcraft, and treats people sick from dreaming they ate bad food. This person was licensed by the municipality as herbalist, occult and sorcerer, soothsayer (7K). The director of the healers' association, who is a medical doctor, further suggested in the same speech that the healers could be placed in medical categories as follows:

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[19] The lists in the text and the subsequent charts are in the same order as offered by the healers.

(a) Generalists
(b) Paediatrician
(c) Surgeons and traumatologists
(d) Obstetricians/gynecologists
(e) Physicians
(f) Psychiatrists/psychologists [Speech Feb. 28, 1994]

These medical "equivalents" are even more forced than the first list. A review of the data in Table 1 shows that the order in which people list the conditions they can heal does not match a Western medical perception of categorisation, nor are the skills sorted in the recorded conversations according to the earlier four-category list.[20] Since many healers are illiterate and are not familiar with

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[20] The terminology of the healers is retained in the table, so the different perceptions of illness are clear. For example, "those that cannot walk" or "the sickness that makes children cry too much" are not directly comparable to biomedical diagnosis.

Table 1: Range of Indigenous Healing Knowledge Among Kenema and Freetown Healers

Code	Name	Village	Gender	Tribe/lan	Healing knowledge
1K-h	Momoh Amara	Kailahun-D	M	Mand/Mende	17 yrs Arabic trng Guinea-apprentice; 36 types of sickness-crazy people, women who don't get their period, infertility, those that cannot walk, impotence, withcraft-cause and cure,toothache, piles, fast heart beat, bone ache, boils, constipation, worms
2K-h	Amie Michael	Kenema	F	Mende	corn rash from stealing from gardens; convulsions, vomiting and diarrhea, TB
3K-m	Abdulai Blango	Largo-D	M	Mende	works with jinals, good descrip; Koranic cures; 7 uses for Islamic ink; fire, water, air; crazy in the head; pregnant and legs swollen with water; tumbu fly
4K-h	Brima Borbor	Tonkia-D	M	Mende	2 types of yellow fever; foreign bodies in eyes (infection-Tekei in Mende); dysentery, ring worm, chest pain, cough, constipation
5k-h	H. Koroma	Kenema	F	Limba	stomach pains, irreg. menstrual cycle, infertility, convulsions, if you eat bad food in a dream, fractures, paralysis, the sickness that makes children cry too much, snake bites, gonorrhea, blindness, deafness, shot with witch gun.
6k-h	M. Jabati	Daru -D	F	Mende	Offensive vaginal discharge; children with swollen breasts, convulsions, piles
7k-h	A. Kamanda	Bo	F		Eye problems, leprosy, delivery (TBA); witchcraft; people sick from dreaming they ate bad food; leprosy; Licensed as "herbalist, occult and sorcerer....soothsayer" see wording of licence
8k-h	B. Lahai	Kenema	F	Mende	Fractures (good chicken Rx descrip); diarhea, split skull (Guble-Mende)
9k-m	F. Lamina	Blama	M	Mende	crazy people, stomach pain, malaria, dark eyes (blind), itching, women's irregular period; ulcers in stomach from sand in food; poison food from witchcraft, edema of feet
10k-h	M. Sheku	Kenema	M	Mende	Keeps at least 4 witches in his stomach---vomits one up. They tell him if sick people are going to get well.
11k-h	M. Mojoi	Kenema	F	Mende	Malaria, pain in groin, scrabs (gaqui-Mende); Baqui also--bird sickness caused by picking fruit from garden with bird ties to board)
12K-h	S. Momoh	Daru-D	F	Mende	Twin (sister there, too); can treat witchcraft, person who has eaten poison food; woman who has not seen her period, family planning, discharging bad fluid (vaginal); child with split head; passing urine in bed, for child to walk quickly, bring someone back from overseas; to keep husb sexually faithful, measles, pregnant with no fetal movement, to speed labour; eat bad food in a dream;if you dream of intercourse with another man; measles, yellow fever, convulsions (sickness that holds adults and children), joint pains.
13K-m	S. Gegbeai	Blama	M	Mende	He is blind-made blind by the jinanga (sing. jina), then given healing knowledge by them. Good description of how Mende jinanga work. Treats sick mind--treated PC Kaisamba when he was crazy. "I am not only a healer but I also help people get positions of power like chief."

14K-h	Y. Conteh	Bumbuna	F	Limba	Yellow fever, TBA, fractures, dizziness, scabies, blindness, treat jina so it doesn't come again, infertility in women
15K-h	P. Dene	Blama	M	Mende	Piles, gonnorhea, fractures, ulcers, leprosy

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__Freetown Interviews:__ (57 interviews with 34 healers)

	Code	Name	SL	Village	Gen	Lang Healing knowledge
1f-c	Abu Kamara	Y	Songo	M	Temne	int. stomach, witchcraft; 40 other diseases
2f-c	Asata Ansumana	Y	FT	F		deliver children, broken hand or foot
3f-c	A Y Kargbo	Y	FT	M		impotency, elephantiasis, dry stomach (retention of urine, constipation), protection from or removal of witchcraft
4f-cl	Sarah Bangura	Y	FT	F	Krio	2 int. Blood in stool, urine, piles, edema, malaria, asthma, TB
5f-cl	H. F. Barris	Y	u/c	F	Krio	2 int. Malaria, abortion, when fever holds a child. people that will not piss, worms
6f-cl	Brenda Moses	Y	FT	F	Krio	2 int. Black Tumbler drink-fresh cold, edema, TB, pneumonia; prophesy; whopping cough, yellow fever, undernourished children, bad milk in the breast
7F-tl	K.A. Boisiako	Y	Ghana	M	?	Skin disease, constipation, piles, malaria, worms, sex weakness, waste trouble, conception
8F-x	Chief Banya	N	Kailahun-D	M	Mende	Not a healer, but concerned that Nancy will take the healers' knowledge
9F-tl	Daniel Conteh	Y				Hypertension--he has the patient from the hospital with congestive heart failure; 7 diseases from a dream: malaria, dysentery, swelling, witchcraft, spider disease, woman that doesn't see her period, constipation.
10f-h	F.Y. Conteh	Y		F	Koranko	2 int. Worms, fortune telling; still birth, birth control, piles
11f-c	T. Garber	Y		F		Fractures, worms
12f-c	Gbanguta	?	Wellngtn	M		Swollen breast from tumbu flies, itchy backside-gonorrhea
13f-c	M. Kabia	?	Wellngtn	F		children whose heads split
14f-h	A. Kaloko	N	Waterloo	F		TBA; hiccups, old people when backbone hurts; women with devil inside them; delivery stillbirth; interesting Rx of cord after birth
15f-c	M. Kargbo	Y	Murraytwn	M		Scabies (clo clo), witchcraft that causes puffy skin, death
16f-c	A. Kobba	Y	FT	M	Mende	2 int. Diabetes (treats it with honey). Med Stud COMAS
17f-m	S. Koker	Y	FT	M	Krio	Does research and teaches at FBC-organic chemistry, medicinal herbs.
18f-h	L. Conteh	Y	Waterloo	M		Side pain, stomach pain, witchcraft, children who pass urine on the bed, hiccups
19f-c	E. Manfo	Y	Ghana	M		gripping pain in the stomach, body or foot swollen, tapeworms, eyes red and painful
20f-cl	M. Mansaray	Y		F	Mende	pregnancy, swollen feet, no fetal movement, abortions, children-marasmus; when child's backbone bends like chameleon (mo wanted food when preg.) Tumbu flies in breast, fractures; dream of sex. int. with man not husband.

21f-m	M. Kargbo	Y	Freetown	M	Limba	Allay, stomach ache, people who come to you in a bad dream.
22f-c	J. Moiwoi	Y	Kailahun	M	?	Dysentery, foot wells, woman who scratches and bad water comes out, ringworm
23f-c	A. Kamara	Y	Freetown	M	Krio	Piles--good descrip of process of treating boro-boro, the dysentery associated with piles, there is blood in the urine and stomach pain; also treats jinahs (convulsions), simple fractures
24f-c	J. Pessima	Y	Freetown	M	Mende	Diabetes with Seme bark--several good healing recipes, excellent story about urine of diabetics on ground for ants--diagnostic tool; also MOTL checked blood sugar after Rx. Good collaboration. Also treats piles, lumps in breast (fibrous) with Vit. E.
25f-h	S. Sessay	Y	Lumley	F	Mende	3 int. Removes power from witches, but doesn't do juju; stroke-paralysis, epilepsy; makru-women's itching in private parts, malaria, worms-tapeworm, asthma, knee that disturbs you; go to the toilet with blood, children with swollen belly; man who wants to score a goal in sports but is not able; hypertension; child that has a fever
26f-m	Sheku Sesay	Y	Pendembu	M	Loko	2 int. Impotence (man business); frog worms--the worms cause a swelling that resembles a frog; piles; dry dysentery; gonorrhea, all kinds of worms, severe headache, rheumatism, cataracts
27f-h/m	BMS Turay	Y	Calaba Town	M	Susu	6 or more ints. Herbalist, teacher, writer.
28f j/m	MOTL	Y	Freetown	M	Krio	8 ints. plus. MD from Russia, treats many things, mix of spiritual and biomedical techniques
29F m	M. Massaquoi	Y	Bonthe	M	Vai	3 int. Piles and many other things.
30F m	O. Kamara	Y	Freetown	M	Krio	Pharmacist trained in Russia
31F-m	Pa O. Kamara	Y	Songo	M	Temne	Withcraft, elder healer
32F-tl	S. Sesay	Y	Songo	M		
33F-m	M. Kallay	Y	Kabala	M	Koranko	
34F-m	I. Kamara	Y	Guinea	M	Treats AIDS	

Key to abbreviations:

D-displaced
H-interviewed at healer's home
C-info gathered at conference presentation
Cl- interview in healer's clinic
TL-interview in Dr. Taylor-Lewis's office
x-interview elsewhere

SL-Member of SLENTHA
K-Kenema
FT-Freetown
M-interview in my apartment
X-interview elsewhere

Western perceptions of order, they may merely list their skills in a haphazard order. More likely there is a different perception of the inter-relatedness of all of these skills, and that my questions and the influence of Western emphasis on order may have forced a selection of discrete categories which can indeed appear arbitrary. For example, I was surprised at first that constipation might be widely separated in the healers' lists from piles, both of which I consider to be conditions of the lower gastrointestinal tract. On no occasion were they listed together. A healer's list like *witchcraft, person who has eaten poison food, woman who has not seen her period, family planning, discharging bad fluid (vaginal), child with split head, passing urine in bed, for child to walk quickly, bring someone back from overseas, to keep husband sexually faithful, measles, pregnant with no fetal movement, to speed labour; eat bad food in a dream, if you dream of intercourse with another man; measles, yellow fever, convulsions (sickness that holds adults and children), joint pains* (12K) defies either of the above typologies. So does another healer's much shorter list, *two kinds of intestinal worms, fortune telling, still birth, birth control, piles* (10F). The lack of an ordering system which can be matched with biomedical categories is a factor which may limit institutional collaboration.

Sources of Indigenous Healing Knowledge in Sierra Leone

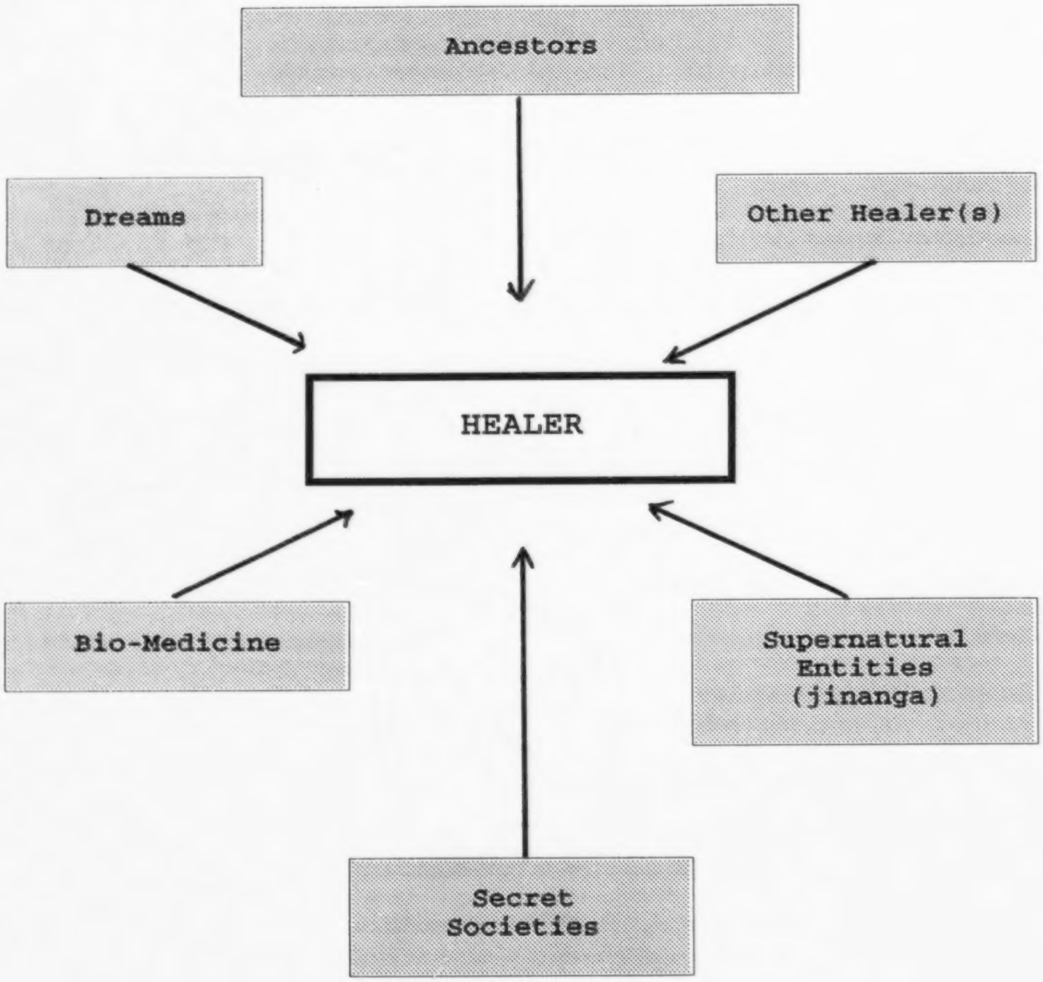
A survey of sources of indigenous healing knowledge is instructive (see Figure 1). The sources are very personalised, and reflect the belief system of the individual healer. A healer may receive his or her knowledge from more than one source.

Dreams are a source of receiving, and also of transmitting healing knowledge. Dreams were the most common source cited (ten healers). Dreams could be of dead relatives, of *jinanga* (spirits of the Mende tribe in the east and south of Sierra Leone) or other supernatural entities (Gittens 1987; Harris and Sawyerr 1968; Little 1967).

> *I dreamed about a jina showing me medicines. They were directing me to know the difference between good and bad people.* (7K)

> *I met one man, and his teeth were seriously aching. I felt for the man, and I said that if I had the knowledge of the herbs and the herbs then I would have helped him. For God.*

Figure 1
Sources of indigenous healing knowledge.


Ancestors
Dreams
Other Healer(s)
HEALER
Bio-Medicine
Supernatural Entities (jinanga)
Secret Societies

> *When I went to bed in the night, I had a voice in the dream that said that it would show me the herbs so that I could heal the man. Then the leaves were shown. Then I used the man as an example and he got well. That medicine is mine for life.* (2K)

One person received direct information from a dream--he was shown the leaf for snake bites (9K). Another healer (12K) places palm oil at the head of her bed, and then dreams for her clients, foretelling their future. The palm oil technique is common to many diviners. Gittens observes that the Mende do not distinguish between "the reality of experiences during sleeping and waking periods" (1987:165).

The process of identifying sources of healing knowledge was complicated by the next most common category, knowledge obtained from relatives (eleven healers). The complexity occurs when the relative appears in a dream and gives the knowledge. This occurred in six cases.

There is a strong family link among healers, in that healing knowledge is often passed on within a kin group. Certain kin groups carry special secret knowledge about particular herbal remedies that are guarded as secrets. It was very common for healers to have learned their skill from a parent who was also a healer, either the father or mother or both. Others learned the ceremonies from grandparents. One (5K) learned from her sister before and after she died (in dreams).

Among those who learned from family members, most did not pay directly for the training, but it was part of the exchange within the household. One (6F) did pay her mother and grandmother to teach her. Others have paid healers who are not relatives to teach them about the leaves.

Many learned from secret societies, including the men's Poro Society (Little 1965, 1966), the women's Bundu (Sande) Society (Bledsoe 1990, 1993; MacCormack 1979), the Ojeh Society and other secret societies, some of which are directed toward healing. It is reasonable to assume that more of the healers than told me obtained some or all of their knowledge from such a source.

It is common for healers to have obtained their knowledge from another healer who cured them. As they were recovering they asked to be taught. Some were taught only the cure for the disease they had suffered themselves, while others became more broadly skilled by serving apprenticeships with the person who healed them.

One healer obtained his knowledge at birth:

> *I was born with some of the leaves, I brought them when I was born. Nobody taught me them. I inherited it from the mother's womb. I started doing the treatment immediately when I had a child.... I started treating the child so that she could walk fast. She walked quickly and others heard about it so I got popular.* (12K)

Guinea is a very prestigious place for Sierra Leoneans to learn about traditional healing, according to many healers. In this study four of the Freetown healers had gone there to learn, spending as much as five years as an apprentice with an established healer. One healer claims his successful treatment of AIDS was learned in Guinea.

The Bundu Society (women) and The Poro Society (men) are time-honoured organisations which predate the colonial era, and persisted despite secret societies being outlawed for a time by the British colonial government (Newland 1916). In precolonial times the secret societies were traditionally the "schools" for boys and girls, the places where they learned from their elders the skills and behaviours required for them to perform appropriately as adults. In the past children went into the society bush (an area that is marked off and forbidden to non-members) before puberty and spent several years there, emerging as initiated adults and accepted as such from then on. In recent years, although the time spent in the bush has been reduced because of the shift to emphasis on school attendance, the societies still have a strong influence. Many female healers learned from other Bundu healers, and many Poro men learned their trade in the Poro bush or from older Poro healers.

Four of my interviews with healers in Kenema were conducted in the Bundu house. This is an enormous building which housed at least a dozen young women, ten older women, and many children. It was hard to estimate exact numbers. There was a large cooking area where food was prepared communally, and another room where several healers served the public. I was privileged to be there, and to talk with these women.[21]

> *I spent seven years in Kailahun [a chiefdom in the Eastern Province] training, secret society training. They train many. They always train only for good purposes, not bad ones.* (7K)

Although I was careful not to ask questions which would jeopardise the secrecy of the Bundu and Poro societies, information was sometimes offered to me during the interviews.

> *I started learning about medicine in the Poro bush. I was taught about leaves by elder members of the society and my father. I learned a lot about witchcraft and came out knowing about 155 leaves and their remedies. Some of my tutors came from places where the Poro Society has very firm roots--Yonibana, Ribi and Sherbroland [Southern Province].* (1FB)

Another important source of indigenous healing knowledge is biomedicine. I found that many healers, particularly those practising in Freetown, had adopted terminology and techniques from biomedicine. I was somewhat surprised to hear the occasional healer use words like herpes zoster, gonorrhea and other clinical terms. Many healers have adopted a solution of water, sugar and salt much like the rehydration salts used by biomedical personnel, and the use of Bennimix (a high protein seed locally processed as a supplement for children). Others use patent medicines such as vitamins and folic acid. Some healers use sterile gloves, and some also use needles and syringes to inject purchased antibiotics, or occasionally herbal preparations.

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[21] I believe it was because the sister of the owner of the Nongowa Clinic in Kenema (Dr. Banya) is head of the Bundu society in the Kailahun District. She was anxious to talk with me at length, but our precipitous departure from Kenema prevented that.

The notion of a patient registration number, perhaps borrowed from the hospital registration systems, was adapted in an interesting fashion by one healer.

> *All of us in this world have an admission number. Just like English people when you came for a flight you get a ticket number) It is the same thing. Two people will not have the same number, even twins. If you hate someone and you find out their number you will take the admission number and your name. For example, if you do not believe me I will take your admission number and your name and mix it with herbs and you will come to love me.*
>
> *You take the number and the name and the herbs of good luck and put them all together in the hole (if you want to block that good luck)-or river, fire, or ant hill. There are four places where you can block good luck. The taking of the number and the name and the leaves is a mathematics method. For example, the calculator. You push the numbers and you get the total response. It is the same thing. Doctors, x-ray and all others will do this.* (1K)

A more general example of this adaptive tendency is the often voiced desire of many healers to have a clinic, either alone or in combination with other healers. This was only voiced in Freetown, and not in the Kenema sample.

Indigenous knowledge is dynamic. Absorption of new techniques from biomedicine does not necessarily weaken it.

Techniques Employed by Healers

Just as an understanding of the sources of healing knowledge enhances the context of this discussion, so does a brief description of diagnosis and treatment techniques.

There are several methods to determine the nature of an illness. The first is direct observation. This process includes for some healers the ability to identify evidence of witchcraft. There may be long procedures to ascertain a natural or supernatural cause, often involving herbs used in special ceremonies, as in the case of tuberculosis which will be recounted by Pa Massaquoi, Key Informant #2. Some diagnostic procedures, however, are very pragmatic. A person who is suspected of having diabetes is asked to urinate on the ground outside. If ants gather there quickly, there is a high sugar content. The disease is then treated with a special kind of bark extract, and when the ants no longer are attracted to a urine sample, the patient is considered healed. Some healers determine diagnosis over night or in a short nap, sometimes with a bowl of palm oil placed close to their heads. The diagnosis occurs to them in a dream, as new knowledge or as a revelation from a dead or distant relative. Finally, some healers may consult their spirits or *jinanga*[22] (Gittens 1987) for a diagnosis.

Perceptions of causation of illness are often founded in past behaviour, either that of the patient or of a relative. This behaviour may be recent, or it may be undetectable without the aid of supernatural divination. Perceptions of illness causation amongst the healers in this study often functioned as social control mechanisms.

> *My mother had seven children but I am the only one alive. After my mother delivered me my father's sister got sick and confessed that she was a witch woman and had caused all the children to die. She didn't want my mother to have children.* (7K)
>
> *If you have a garden and you do not want anyone to disturb it tie a bird to a board and place it in the garden. If someone goes in an picks the fruit, they will become ill with bird sickness. It will make you tremble, like a bird trying to fly. It will look like convulsions.* (11K)
>
> *Something appears on the body that looks like corn. This is because the person has eaten from a garden that has corn in it which was protected by a Koran herbal mixture with ink. If they eat from the garden that is not theirs which is protected in this way, they will get these marks on the body as a rash.* (2K)

Witchcraft

Witchcraft is the fabric within which the illnesses relating to social control are woven. Witchcraft is ubiquitous in Sierra Leone. Some soldiers in the north wear bullet proof shirts prepared by witches to protect them. The sunken fontanelle of babies and small children is caused by witchcraft of a serious sort that is usually fatal.

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[22] *Jina* is the Mende word, singular, for a devil or supernatural spirit; *jinanga* is the plural. Despite the translation, used by indigenous people as well, of "devil" these beings are not necessarily evil.

There are certain sources of this kind of knowledge, the Poro Society being just one. There are villages such as Songo and Kabala known for the power of their healers to perform or counteract witchcraft--or both.

Witches can differ. Some are the *jinanga*,[23] the spirits of the Mende who play a variety of roles, protecting those with whom they are associated and often playing a partnership role in diagnosis and healing. One man could call and see his *jinanga* by looking in a special mirror. He brought them into my living room during the interview, but I did not have the skill to see them when I looked into the mirror, an event which was not surprising to either of us.

Another healer carried his witches in his stomach. He was happy to show one of them to me. He prepared and drank a herbal tea, then vomited a brown cone-shaped object about four inches long. This was one of his witches. It lay perfectly inert in a bowl while I photographed it, whereupon the healer swallowed it again. This particular witch permitted his host to ride on a banana leaf from Kenema to Freetown or to Germany at night.

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[23] The word *jinanga* is the Mende plural for *jina*, a spirit often invoked by healers and diviners.

A very venerable healer in Kenema, reputed to be the leader of the healers in the region, came to my apartment, guided by his son. The healer was blind. A *jina* in a dream had made him blind in about 1940. In 1950 the *jina* appeared again and gave the man healing knowledge, and later a wife and six children. He now has about six *jinanga*, each of which does different things. Other healers use the same ones as he does.

This healer and many others use verses from the Koran in their healing practice. A brown ink is prepared from special leaves. Flat wooden tablets are prepared, and verses from the Koran are written with sticks on the tablets. Later the ink (the verses) is rinsed off with water and the water is used to treat a patient. It may be swallowed or used to wash part of the body. This technique is used by many male Islamic healers.

There are special powers of healing and divination attributed to twins, and many healers are twins.[24] Often one of the twins did not survive birth. I conducted interviews with two women who were adult twins and both were healers. One was given her "witch" by her mother, also a twin.

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[24] My daughter who served as my research assistant in Sierra Leone is a twin. Being the mother of two sets of identical twins gave me a decided advantage in some of the interviews.

I have spent some time describing aspects of witchcraft as a cause of illness and a technique for diagnosis and cure because it is not separate from illness, healing or any other aspect of life in most of Sierra Leone. It is part of the healing knowledge of many of the healers with whom I worked. Supernatural power is one option in an overlapping range of treatments.

Many methods of treatment are very pragmatic. The technique for timing the healing period of a fracture is an example. Once the patient's fracture has been set with a splint made from a special kind of wood, the leg of a live chicken is broken. As soon as the chicken can walk again, the fracture is considered mended.

In other cases the treatment of choice may be determined by the perceived cause of the illness, such as allaying the power of a curse:

> *I can mend other things like stomach ache. If someone comes to you in a dream, bad people, and they put a sickness on you, the doctors will not be able to heal you. I will give the patient a leaf and they will eat it and the bad that is in the belly will not stay. It will come out in the stool.* (21F)

> *Some people get a bad jina, which makes the person unconscious with convulsions, fighting the jina. I treat them with leaves, sometimes I put palm oil inside the leaves.*

At other times the healer may offer symptomatic relief (herbal decoctions for rashes, for relief of pain).

> *I cure rheumatism by grinding herbs and rubbing them on the affected parts.* (26F)

Influencing the Future: Prevention and Divination

Healers play a strong role in prevention, as well. This often entails ritual behaviour such as wearing a particular item or performing a specific task. Many healers offer family planning, or birth control effected by the woman wearing a rope around her waist woven from a particular kind of bark. There may also be a cowry shell with a herbal powder inside it attached to the rope. There are a wide variety of protective devices, often ropes or necklaces, or special ceremonies which protect the individual from certain kinds of witchcraft. There are also herbal mixtures that, when taken daily, may act much like a tonic for the healer, his patients and his family, keeping them healthy and resistant to disease. Future events can be influenced by prescribed charitable acts, also (Krio: *chanty*). The power of a prayer for a particular outcome, such as prevention or cure of a disease can be enhanced, for example, if the person purchases some candies in the market and distributes them to the children in the street, or by giving money to a beggar.

Referral: Microlevel Collaboration

If the healer cannot identify the reason(s) for the illness or if, once identified, the treatment is outside the healer's expertise, the patient may be referred elsewhere. Most often this happens when a healer who doesn't cure witchcraft, discovers a supernaturally caused disease, or when a healer detects a problem for which surgical intervention is advisable. Half of the healers in the Kenema group occasionally referred patients to other healers.

There were several examples of referral to healers from biomedical personnel on an individual level. The doctor who is head of the traditional healers association referred two infertility cases to a traditional healer in the association and both were successfully treated after the doctor had tried for three years. Referrals in this direction, biomedical to traditional healer, were very unusual, however.

Referrals from healers to biomedical personnel were more common. One healer always refers any fracture case with blood and bruising to the hospital for a tetanus shot (8K). Another healer is told by her *jina* when a patient should be referred to the hospital for an operation. Yet another refers call girls to the AIDS medical specialist for a blood test and free condoms.

Traditional healing is clearly an individualistic occupation in Sierra Leone. Most healers work independently. There are some who work with relatives, and there are some who have one or more apprentices. The general pattern, however, is independence.

Economic and Ethical Considerations

The issue of economic motivation for sharing of indigenous knowledge is important to the understanding of the situation in Sierra Leone. Most of the healers are facing serious economic difficulties. Those in SLENTHA were led to believe that I was bringing them money from Canada, an expectation which I worked to erase. Many carried the expectation of money with them for some time:

> *We have to impress you so you'll give us your funds...We don't have any money, we want money.* (6FB)

My claims that I did not have money to give to them were met with frank disbelief. As one healer observed, "You got to Africa, didn't you?"

There was a difference between the healers in Kenema and Freetown in terms of their attitude towards me, in that many people in Kenema knew me, or knew of me. At the time of the interviews the people of Kenema had not yet been displaced by the war. Although their households were overflowing with displaced relatives from neighbouring villages, they were still managing, and there was a supply of relief food in town. They also knew that the small hospital with which I was associated was caring for most of the civilian wounded--often their friends and relatives. Five of the fifteen healers interviewed in Kenema supported themselves and their families from their healing alone, while in Freetown only one was managing this way. Throughout Sierra Leone it has become adaptive to have several small business enterprises within each family, and most draw their incomes from many individuals and many sources. This was particularly true of Freetown, and is true even of Kenema, now that the supply road has been closed for some time and prices of rice and other foods have more than doubled.[25]

Some healers directly augmented their income by selling the herbs that they collected in the market to the public or to other healers. Only a few did this, as there appears to be a strong sense of responsibility for gathering your own herbs. Many healers believe that the herbs in the distant provinces are better than those near Freetown. Access to the provinces is limited just now because of the war. Some Freetown healers purchase their herbs now, some send relatives to collect the herbs, and some still travel up-country themselves from time to time.

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[25] It is important not to stretch the comparisons between the healers of Kenema and those in Freetown. The war has caused extensive migrations within the country, and so the rural -urban dichotomy doesn't always hold. The war-time economy places strains on everyone, blurring patterns which might have been more distinct in pre-war times.

It is difficult to get a sense of the income from the healers because of the disruption of the wartime economy and the displacement of so many people. Many said that they earned their family's total income from their healing activities, but this must be weighed against the time-honoured pattern of everyone in the family being involved in petty trading in some small way.

The question of payment for healing services is bound up with ethical beliefs, particularly in the rural villages. Payment is rarely expected until treatment has been successful, although it is expected that the patient will give a "small thing" for the healer to take to the bush to leave in place of the herbs that are collected. The small thing is usually somewhere between one hundred and five hundred leones (between twenty-five cents and a dollar twenty-five). It is also believed that if the patient does not eventually compensate the healer, the treatment will not be effective. There are exceptions to this, of course, where healers treat indigent patients "for God," at no charge. This is exacerbated by the war and the displacement of those who would normally pay with cash, produce or labour in the village setting.

In Freetown there is a trend to cash payment, and to higher fees in some cases, as competition with biomedicine becomes more pronounced among the local and displaced healers, and also from the influence of biomedical doctors, who generally charge cash fees in advance of treatment.

In both settings, rural and urban, many healers assured me that there was no charge if the treatment was not effective.[26] There is also a corollary to this: if a healer takes money from a patient who dies, the healer will come on bad times (10F).

Healers in both settings also spoke of their reluctance to treat someone who was likely to die. There were several strategies to address this situation. One was to send the patient to another healer. Some sent the patients to the hospital. Others, when they saw the white star or white light above the patient's head which signified impending death, or when their *jinanga* told them that the patient would not survive the illness, would simply refuse to treat the patient. Most were gentler than this: *I tell the patient that I could not find the herbs. If he is smart he will know* (5F).

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[26] I experienced this with a western-trained pharmacist in Kenema when I purchased some antibiotics for a severe cold. He refused to charge me until I was healed, and then asked me what I wanted to pay. I asked him what the medicine cost him, and then added a bit more.

There were instances where the healer did not know at first that the patient would not survive (5K). This was discovered when the healer went to the bush to collect the appropriate herbs, and they could not be found. This meant that the patient could not be healed.

The eagerness which I encountered on the part of the healers to impart their knowledge to me is evidence that the perception of ownership, if it is a strong motivation for secrecy, did not extend to me and my research as they understood it.

Instead, there were consistent indications that ownership was not an issue, and that sharing was a positive goal, for two reasons: one was economic gain, and the other was to perpetuate indigenous healing knowledge beyond the present generation. The few who were literate wrote their herbal recipes down. Some of those who were not asked me and others to do it for them.

Implications of the War for Indigenous Healing Knowledge

The war was a major cause of economic hardship for the healers. At the time of this research Kenema was much more seriously affected by the war than the capital city of Freetown, 192 miles west. During the three months that I lived in Kenema the war caused a periodic influx of hundreds, and sometimes thousands of displaced persons from surrounding regions. As the months wore on an anxious atmosphere pervaded the daily activities of those of us who lived in the town. A passage from my journal on February 23, 1994, describes the sense of crisis and chronic anxiety that currently pervades Sierra Leone:

> The war came to Kenema at 12:20 A.m. There was an incident at the Bracadie Bar two blocks from our apartment, between the Sierra Leone soldiers and the Poro Society patrols. The soldiers were to be off the streets from 10 P.M. until 6 A.M. following a crisis of confidence in the loyalty of some of the military battalions. The Poro Society, the men's secret society, had volunteered to patrol the street during that time, and we had become used to being lulled to sleep by their chanting as they passed in the streets below.
>
> This night was different. Some soldiers staying at the motel were sitting outside drinking after midnight. The Poro patrol told them to go inside because of their curfew. One soldier fired into the air. The danger signal drummed across the town and in minutes the street was filled with men running to the site of the shooting. Hundreds, perhaps thousands of men came to protect their Poro brothers carrying sticks, some with machetes. They were not armed. The soldiers were attacked--one was killed, and two of the Poro men were killed. The motel was razed. There were gun shots and fear in the air all night, mixed with the Poro chanting.
>
> Silence in the morning. An absolute curfew. No shops opened, no one in the streets. Eventually a friend came through the side streets to check on my daughter and me. He is a leader in the Poro society, although this is never acknowledged or discussed. He stayed for a few moments, then vanished into the cluster of huts across from our apartment. The town seemed empty all day. Fear floated along the streets, seeping into every compound through cracks in the walls, sliding over fences, slipping in the windows and into the hearts of the people. Babies didn't cry, dogs didn't bark, no cars were on the road. Only army vehicles. We were told that the Bracadie Bar had been destroyed by the Poro devil. Eventually three municipal leaders were arrested and taken to prison in Freetown--a symbolic act.

After this event one Kenema healer stopped practising all together, fearful that unfamiliar patients might be rebels (2K). Another was afraid of me until she recognised my interpreter, and she still required considerable reassurance. She was displaced to Kenema and living with relatives. She had left her own village because rebels had tried to find her to take her with them to treat some of the rebels. They are known to have abducted some healers, local nurses and dispensers.

Other healers were concerned that since none of their patients could pay any more, they would never be able to buy the licence from the municipality, and would be discovered practising without it (2K).

Another serious effect was a result of "National Cleaning Day". The last Saturday of each month has, since the advent of the NPRC government, has been designated cleaning day. No one is allowed to leave their home until 10 A.M. The streets are patrolled by soldiers who ensure that everyone is cleaning their compound and the road outside the house. People have been beaten, killed or imprisoned for disobeying this regulation. All shops are closed. The soldiers check all compounds, and they pull up any plants with which they are not familiar. Many healers complained that all their medicinal plants had been destroyed by the soldiers in the name of Cleaning Saturday.

An important benefit for some of the healers with whom I worked in Kenema, and later in Freetown, as the war approached the capital city, was the transportability of their trade. Healers were able to adapt to their new surroundings more readily than many of the other displaced people who had been farmers or traders of local merchandise.

Some effects of the war were less direct. One healer (3K) had twenty apprentices in his village, but the war had scattered them all. He was concerned that there would be no one to teach, no way to pass on his knowledge. Issues of food and lodging had become paramount, and training was a fading memory and a faint hope for the future (3K). The apparent long-term nature of the war is a deep concern for the older and more experienced healers, who see their knowledge dying with them.

SECTION II: THE KEY INFORMANTS

Key Informant #1: Mr. B.M.S. Turay

Biographical Sketch

Babara Morie Turay was born in Kambia District in the northwest of Sierra Leone. His family are Muslim and Susu by tribe. None of his relatives were healers. He currently lives with his wives and children.

Mr. Turay, a botanist, became interested in the medicinal qualities of plants in 1981 while he was working as curator of the herbarium in Njala. He has since become a proficient healer, and operates a busy practice from the clinic in his home.

Although he describes himself as *a general practitioner in Traditional Medicine or Traditherapy* (speech for April 15, 1994), Mr. Turay also has a scientific background. He received his undergraduate degree from the University of Sierra Leone, an honours B. Sc. in botany. In 1981 he received his masters degree at Reading in the U.K. His research was in applied plant taxonomy. He has taken two additional short courses in Nigeria, one on weed control and the other on plant tissue culture. He has worked as a teacher in secondary school and as a lecturer and curator of the herbarium at Njala University College. He has written several books and papers on plant taxonomy and weed control.

His current research is on cocoyam production in Sierra Leone.

The research relationship

I had lunch with Mr. Turay on my first day in Sierra Leone, and conducted my first interview there, followed by several visits to his home/clinic, and many informal visits in my apartment in Freetown. I also accompanied him and another colleague to the bush to collect medicinal plants on one occasion.

The table on the following pages outlines the various sources of data and the key themes and sub-themes as they relate to this discussion.

Table 2: Data Sources and Themes for Key Informant #1

Date	Source	Themes		
		Collaboration	Indigenous Medical Knowledge	Other
4 Jan 94	interview #1	-med school separate	-need for herbal pharmacopia -need for training herbalists	goal: herbalism is retirement security
6 Jan 94	interview #2	-Christianity & orth med -orth med, active ingredient -botany students research med plants -exchange with botany students/healers -need group more scientific than SLENTHA -teaches ecology, taxonomy, etc.	-clinic at home -writes to preserve IMK -sees pts from US, London, France -apprenticeship other healers -healers need training -healers want to monpolise -secrecy: monopoly or ignorance? -he diagnoses, unlike THPs -should be regulation of THPs -gov't should give recognition -ownership of knowl-suspicion -2 models of association -prefers to stay home at clinic for "pecuniary benefit" -is on SLENTHA exec, inactive	-expecation that I will help get money by writing, WHO -manuscript of medicinal plants of SL
9 Jan 94	interview #3	-planned herb farm, new site of medical college, Jui -teaches medical botany -wants Inst of Trad Med at Med College- -healing research and products -coop with SLENTHA -Inst of Extramural studies & illiteracy	-availability of herbs -different plants upcountry -Islamic context of healing -Islamic verses healing diseases -potential problems with SLENTHA -effect of fire and logging on plants -need to preserve endangered species	-has garden in Kambia for retirement -concern for retirement-over 40 -has manuscript of med. plants in SL
30 Jan 94	proposal for Faculty of Pharmaceuti-cal Sciences	-description of pharmacognacy		
23 Feb 94	Curriculum Vitae	-Science bkgd -botany/taxonomy -lecturer COMAHS -lab investigation	-folk medicine -healer -improve TH methods	
28 Feb 94	Speech symposium		-learned from other herbalists -treating sickle cell for 9 years, studies	

5 Apr 94	Notes from meeting	-sickle cell anemia as prototype for collab studies	-skin rashes which can only be cured by trad healers	-my influence in BMS and MOTL working together
5 Apr 94	Research proposal for Trad Healing Centre	-joint development of herbal and trad med. -reduce dependency on foreign drugs, save fgn exch -advantage of being healer with scientific knowledge -minimising risk of accidents for healers -goal-make TH part of ntl health program -coop bet TH and mod med pract.	-reasons why TM still practised -prepared list of med. plants for cattle in north -no gov't money spent on trad healing -secrecy/monopoly (ownership) -loss of IMK--need to preserve -Kenyan plant suppresses cancer -note: need to preserve knowledge and plants! -risk of practising TM-illegal -commitment to salvage TM -superiority of TM in sickle cell crisis -healers play central role -contents of training program	scientific perspective -artificial class. of med. plants -history of research on med plants -has assisted with plant research in Canada, US, UK, Germany-collected -centre for research into and improved use of plants
14 Apr 94	Speech for German embassy evening	-role of 'enlightened' to cooperate... -advantages of collaboration to SL	-defines himself as pract of T.M -need for faith -sickle cell success -ailments he cures listed -lists those caused by magic (contrast with scientific trng)	

Implications for Collaboration

Mr. Turay's rich background of scientific experience combined with his commitment to traditional healing presents an unusual example of microlevel collaboration. He is linked to biomedicine through his position as lecturer in the Faculty of Pharmacy at the College of Medicine and Allied Health Sciences (COMAHS), part of the University of Sierra Leone, where he teaches medical botany--taxonomy, ecology, anatomy and morphology of plants.[27] The field in which he teaches is called pharmacognosy, *that branch of pharmacy which deals with the study of drugs of natural origin i.e. those drugs derived from plant, microbial and animal sources* (Proposal for Faculty of Pharmaceutical Sciences, p. 36U). He comes to traditional healing with two perspectives: one is his life-long interest in plants and their properties, and the second is his pragmatic wish to augment his present income and ensure *social security* for his family after retirement (Int. 1, 2, 3). Despite his appointment at COMAHS he spends much of his time at his home operating his clinic. The university in Sierra Leone has been open intermittently over the past year because of the instability of the country. Salaries for instructors, which are very low under normal circumstances, are only paid periodically. As in most professions in the country, professors have other sources of income, and teaching is not their major activity. Thus although Mr. Turay has an office at the medical college in Freetown, I always met him at his home unless he dropped in at my apartment. His visits to the apartment became very rare in June, after his car broke down. His home in Calaba Town is on the eastern edge of Freetown and public transport from that distance is costly.

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[27] His entry into the field of healing with a botanical perspective explains why he also includes research for herbal remedies for animals. He has prepared a list of medicinal plants for cattle (Apr. 5 proposal).

Mr. Turay's practice is inherently collaborative. He believes that his combination of skills has much to offer both doctors and healers:

> *We have to work together. I am able to say this right now with some degree of precision because of my background. I went to university and did biology and botany for a B.Sc. Then I went out and did applied botany for M.Sc. So I have lots of experience in the scientific community. I can do diagnosis because of my anatomy and physiology and I can respond that this is the herb that is needed and where to get it* (Int. 2, p.5).

Because of Mr. Turay's training and position, he works with both scientists and traditional healers. Students in his courses conduct research on medicinal herbs in their home areas, adding to Mr. Turay's knowledge of medicinal plants. In this way Mr. Turay has amassed the data for a manuscript on medicinal plants of Sierra Leone.[28] He tries to assign the students to their home areas because they speak the language and have a firm foundation in the indigenous culture. The ownership question is addressed through the cultural affinity of the students and the healers, who are often their kin. This collaboration remains on a microlevel between student scientists and the indigenous healers.

Microlevel collaboration is enhanced by the kinship system. The kinship system crosses all educational and class barriers, permitting access to restricted knowledge which is not perceived as appropriation. The value placed on education, even in the villages, is a strong motivation for healer-relatives to offer assistance to students in the form of data for research papers.

The research reports and theses of these students become part of the collection of the library of the University of Sierra Leone. In practice circulation is limited due to frequent closure of the university and to the theft of documents. Thus written records do not in themselves constitute a complete strategy for preservation or perpetuation of indigenous healing knowledge. Accessibility and circulation mechanisms are also essential components. Mr. Turay tries to keep a copy of each paper himself but photocopying costs are prohibitive.

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[28] This manuscript was carried to Canada by Dr. Young and is being published at the Centre for the Cross-cultural Study of Health and Healing at the University of Alberta. The processing of the manuscript is being funded by the University's Fund for the Support of International Development Activities.

In Mr. Turay's own practice he is primarily a herbalist. He has applied his scientific bent to his practice by emphasizing accurate diagnosis more than most traditional healers do.

> *In order to be more accurate with my diagnosis, I now refer most of my cases to the laboratory at the Njala University College Health Centre for investigation before the administration of any form of medication. This is perhaps an improvement on the traditional healing methods* (C.V., p.3).

He believes that *accurate diagnosis has been one of the main criticisms of traditherapy*[29] and that healers should be taught to diagnose more specifically.

> *If you are suffering from milahasia, there are two types of this ailment Schistosoma haematobium and Schistosoma mansoni the one that settles in the rectum and the one that settles in the bladder. You should be able to tell before you prescribe a herb* (Int. 2, p. 5).

Although he believes that *orthodox medicine [has] gone a long way in corroding traditherapy* (Apr. 14 sp.) there are many good reasons for collaboration. Traditional healers can be trained:

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[29] This term was only used by Mr. Turay. He frequently referred to his field as "traditherapy." It is not (yet?) a common term in Sierra Leone.

> *If some of us who are enlightened could cooperate with these people, harness the virtues of the practice, and help them to minimize the risks in traditherapy, then we could be successfully in helping to guarantee health for our generation and those yet unborn. Of course in the process, we could also utilize the talents of traditherapists in sorting out patients who can be treated either way. By so doing, delays in treatment, cost of treatment, and inconvenience would be minimized. Furthermore our dependency on imported drugs would drop and our scarce foreign exchange would be saved* (Speech Apr. 14).

Although many traditional healers are illiterate, the Institute of Extramural Studies in the proposed Healing Centre (see next section) can develop training programs for those who cannot read (Int. 3). It is the role of people with formal training to create opportunities for collaboration (speech April 14). He suggests that a prototype for collaborative research is sickle cell anemia (Notes Apr. 5; Speech Apr. 14).

> *I have succeeded in providing relief for over six years through the use of traditional herbal medicines. We all know sickle cell to be a genetic disease and I am certain that my treatment does not change the genome of the individual. I am of the hope that if I have the cooperation of Medical Doctors, Physiologist, and Pharmacologist, the active ingredient of these herbs would one day be isolated and identified. It will then be more readily available to others suffering from sickle cell anaemia.*

This can be accomplished as part of the program of activities for his proposed Traditional Healing Centre. The proposal for the Centre is well-developed, and awaits a change in the economy and government approval. It is a model for collaboration at the institutional level.

Proposal for Traditional Healing Centre

This proposal will be examined in some detail because of its many collaborative characteristics. As it is envisioned by Mr. Turay and the Head of the Faculty of Pharmacy, *the ultimate target is to make herbal and traditional medicine part of our national program.* It is a model which was developed under the umbrella of the College of Medicine and Allied Health Sciences. Despite its academic origins, it has a strong component of traditional healers. Once the centre is established, its first activity will be the recruitment of twenty-four *contact herbalists from around the country* (Proposal, p. 8).

> *Each contact healer is expected to create an organisation of healers from his section and he/she is recognised as head-healer. All head healers are accountable to the Co-ordinator in Freetown.* (P.8)

Once that is done, modern medical practitioners, pathologists and biochemists will also be recruited as researchers and collaborators. The specific objectives of the centre listed in the proposal are:

1. Establishment of healing centres around the country.
2. Identification and compilation of a list of renowned herbalists in the whole country.
3. Collection of data on the ailments that herbalists can treat and the plants that they use in the treatment.

4. Collection of samples of medicinal plants and setting up a herbarium on medicinal plants.
5. Botanical studies of medicinal plants.
6. *Collection of propagules of selected species of plants which are in short supply but they are quite useful for subsequent establishment of farms in order to insure continuous supply.*
7. *Development of appropriate technologies for the processing and standardization of dosage and administration of different medicines.*
8. *Training of Herbalists.*
9. *Improvement of child care and nutrition.*

This model is an approach which puts the healers in a central position from the outset and during the development of the collaborative process. They are also key to the monitoring and evaluation activities.

Research design is clinically based, in the sense that

> *From the perceptions of the traditional healer and the local community of the concept of ailing conditions, the locally known diseases are identified. The herbs used in each treatment would be recorded and herbarium collection would be obtained. Programmes would be developed for the testing of the efficacy of the herbs (both in vivo and in vitro).*
>
> *All herbal preparations are crude and our programme will not involve extraction and purification of active ingredients. It is hoped that, at a latter date, funding will be solicited for a natural product laboratory.* (P. 9)

This design for a Centre for Traditional Healing is a valid model for collaboration. It differs from other models in that the traditional healers are central from the outset, even though the originating individuals are from a scientific (distinguished from a biomedical) background. The biomedical perspective pertains, in that the Centre would be part of the College of Medicine and Allied Health Sciences.

Implications for Indigenous Healing Knowledge

Mr. Turay, in his prepared speech for the German Ambassador's evening, defined two clear kinds of diseases: those with and those without a supernatural association.

> *Ailments such as hypertension, hypotension and diabetes have also been effectively controlled by the use of herbs. In addition to the above complaints, I have also successfully handled the following conditions;*
>
> 1. *Constipation*
> 2. *Snake bites*
> 3. *Swellings and Oedema*
> 4. *Chicken Pox and Measles*
> 5. *Fevers*
> 6. *Diaresis*
> 7. *Genital Failures (partial or complete)*
> 8. *Menstrual disorders*
> 9. *Child health*
> 10. *Maternity problems*
> 11. *Quick child delivery*
> 12. *Venereal diseases*
> 13. *Haemorrhoids (Piles,Schistosomiasis etc.)*
> 14. *Diarrhoeal diseases*
> 15. *Problems of Alimentary canal*
> 16. *Pulmonary troubles (eg Asthma)*
> 17. *Arthritis*
> 18. *Skin diseases*
> 19. *Eye, ear and mouth disorders*
> 20. *Paralysis, epilepsy and convulsions*

> *There is nothing magical about the treatment of the above complaints. For each, I use various herbs either singly or in combinations. In traditional societies, however, certain spiritual magical powers are associated with plants and animals. The following complaints have been discovered to have been inflicted by magical means;*
>
> 1. *Continuous erection of the penis*
> 2. *Dysmenorrhoea*
> 3. *Complete inability to urinate and defecate (Gbagba)*
> 4. *Impotence*
> 5. *Paralysis*
> 6. *Cases of Witchcraft (e.g. Fange, witch gun etc.)*
> 7. *Bush devil and other types of devils*
> 8. *Peppery sensation of the skin*
> 9. *Alle*
> 10. *Dry cough*
> 11. *Certain eruptions of the genitals (both male and female) which may look like syphilis*
> 12. *Stiff neck and sore throat*
> 13. *Some stomach complaints*
>
> *My knowledge about such complaints is still incomplete. I am only reporting those that have been reported in my Health Centre. If any of the above complaints are inflicted by spiritual means, the orthodox medicine would find itself wanting in their treatment* (Proposal, p. 2-3).

Turay's definition of the conditions addressed by traditional healers includes the spiritual. There is a spiritual and ritual component in his own practice. He, as a Muslim healer, uses the Islamic verses as a remedy. When I visited the clinic in Calaba Town I observed his assistants copying verses from the Koran in a brown ink onto large wooden tablets. He explained the spiritual element of healing:

> *Islam is really more adaptable to traditional medicine than Christianity. I am not aware of any Christian books that deal with healing through herbs. The Koran*

> *itself has nothing to do with traditional medicine but the traditional medicine has been part of the culture of the people where the Koran comes from. My colleagues have lots of examples of healing techniques that are written in Arabic. So you see that Islamic culture blends really well with the traditional culture especially with the rural settings.... By itself some of the healing is not purely herbal. They invoke certain things in the Islamic context, they write certain Islamic verses which they include in the healing. [They] write them down, even on a tablet or on a piece of paper and then wash it and then it serves a useful purpose. [The liquid] is Included with the herbs. Most of our cures for mental sickness are done that way and cures for paralysis. We do it that way. You have lots of herbs and many treatments. It is partly spiritual and partly herbal. If we extrapolate the Islamic fashion, you mix incantations with the herbal treatment and you see the result. The traditional healers have the same thing, they mix their own incantations with the herbs. They are really the same thing because both of them assume that there is some supernatural power that they are evoking which is helping the treatment to go on effectively. So you have that spiritual flavour to the whole thing* (Int. 3, p. 4-5).

Islamic healers and indigenous healing knowledge are equated in Turay's view. The spiritual overlay is simply part of effective traditional healing.

Although he acknowledges a risk attached to practising traditional healing, in that it can be perceived as *illegal* (Apr. 5 proposal), he is committed to *salvaging* and improving traditional healing methods. He expresses the concept of risk as shared by all traditional healers, and expands it to include the risk of *accidents* in practice. His strategies to reduce these risks are incorporated in his proposed training program for the healers at the centre:

> *During each workshop, the healers are encouraged to exchange information quite freely and in turn are trained in accurate diagnosis, personal hygiene, sanitary conditions, and relationships between disease and disease-causing organisms, data collection and record keeping* (Proposal, p. 9).

B.M.S. Turay's unique perspective is reflected in this project design, arising in part from his integrated fields of knowledge. Collaboration, which implies a linkage of two separate entities, may be inherent in the personality of a key figure, in this case, Mr. Turay.

Preservation of Indigenous Healing Knowledge

Turay's botanical perspective also colours his emphasis on preservation of healing knowledge. For him there are two important aspects of preservation of indigenous knowledge: one is the knowledge held by the healers, and the other is the preservation of the medicinal plants themselves, some of which are endangered. He addresses the first issue by writing articles, by recording healing recipes of his own and other healers, and by preparing a manuscript on the medicinal plants in Sierra Leone. He would like to see a pharmacopoeia of medicinal remedies. He has personally contributed substantially to the recording of indigenous medical knowledge, and intends that this will also be continued in a more formal fashion once the centre is established. At the Centre knowledge will be preserved, but it will also be disseminated in the classrooms and herbarium.

To preserve medicinal plants he has a small farm in his home village in the north (which is also an investment for his retirement) and a garden near his clinic in Calaba Town. His work at salvaging rare species during his years at Njala, and his proposal for a herbal farm associated with the traditional healing centre are also strategies for preservation, since indigenous healing knowledge will be lost if the herbal components of the remedies become extinct. He is concerned about the effects of logging and of fire from agricultural burning. He observes that there are different plants in various parts of the country, and believes that the claim that the ones up-country are better is *rubbish*. He is concerned, however, that some of the plants are being over-harvested and are not regenerating or being replaced.

Mr. Turay's conception of indigenous healing knowledge is inclusive. He does not make a sharp distinction between the knowledge of the traditional healers and the plants from which the remedies are drawn. His knowledge base embraces botany, herbalism, Islamic spiritualism and elements of biomedicine.

Ownership of Indigenous Healing Knowledge

A theme which occurs several times in the data is that of the secrecy of traditional healers. He raises this issue in his second interview and in his centre proposal. He understands this issue as *monopoly:*

> *Some still don't say what they do, they want to monopolize. They talk about the reason for not saying what they do because as it is inherited, some say that they get it by dream. It is all monopoly* (Int. 3, p. 4).

> *There is a tendency to be reluctant in releasing information concerning the therapeutic values of plants on the part of some herbalists. They may be afraid of losing their monopoly of the trade. Quite often a lot of useful information is lost when they die without passing on their knowledge. In this way the society gradually loses knowledge about medicinal plants from generation to generation. Unless a positive move is made towards the changing of this trend, this part of our heritage will eventually be lost* (Proposal p. 6).

Mr. Turay understands the sense of ownership displayed by some healers, but feels that it is partly a family obligation and partly economically motivated. His commitment to preserving indigenous healing knowledge causes him to see this secrecy as a barrier to the goals of preservation and recognition of the validity of indigenous healing knowledge.

> *The healers come to the [SLENTHA] meetings and listen to us with some suspicion. Just as I talk to you now. You talk to me and I am suspicious a bit that you are coming to get my knowledge free of charge. That is how the traditional healers work, they come and they listen, and they hang on to what they have. But you*

> *have to start from somewhere. Put something into action. You say, this is what will be beneficial to you and when it is working, then you can have some recognition* (Int. 2, p.4).

Mr. Turay is a member of SLENTHA and was listed on the executive when I first arrived, but he is not active. He did not attend a meeting in the nine months that I was there. He claims that he is too busy with his practice, and that he feels pressed to do what is most important in his life just now. He did attend both symposia, making a brief presentation at each.

He also voiced some doubts about SLENTHA, and suggested that a better model would be one like his centre which will be directed by the healers themselves.

> *Quite often, because of the bureaucratic procedures things will fail if you have too many people to deal with. The college will be only an umbrella. Then you can be responsible for directing things in the area of the government. But if you are involved with SLENTHA and some problem crops up, what will you do? You going to the college or to SLENTHA, which one will channel your problem to the government? There is no problem with aligning with the college and working in cooperation with SLENTHA. For instance, we have the Institute of Education in the University of Sierra Leone which is serving the Ministry of Education. The activities in the ministry are run by the institute but still under the university* (Int. 3, p. 6-7).

Mr. Turay's interest in collaboration without too many bureaucratic layers is clear. Mr. Turay observes that there are several diseases which are better treated by traditional healers than by orthodox doctors. As well as those caused by *spiritual means* listed above, he cites sickle cell anemia and many skin rashes. He believes accurate diagnosis is a weakness in both kinds of healing and collaboration might improve this problem for both. The fact that he was quite willing to explore collaboration with SLENTHA in spite of his doubts, is an indication of his commitment to a collaborative model on an institutional as well as on a personal level.

Key Informant #2: Matthew Vincent Massaquoi

Biographical Sketch

Mr. Massaquoi was born in southwest Sierra Leone in a Vai chiefdom in 1914. The Vai people migrated to Sierra Leone 800 years ago, being forced south from Mali. They currently have four Paramount Chiefs and occupy parts of southern Sierra Leone and neighbouring areas of Liberia. Mr, Massaquoi was one of triplets, but the two girls died at birth. This multiple birth is a partial explanation for his healing power. All of his family are healers, parents and grandparents. They lived near the Gola rainforest in the Southern Province where there are still trees hundreds of years old. The quality of plant medicine there is high. He was also training his children to be healers, but they all live in other provinces and countries now. There is less time available, and many are sent away to school. Mr. Massaquoi and his wife had 10 children. His wife died seven years ago, before the war.

Mr. Massaquoi attended a Catholic school in Liberia as a boy. He spent fifteen years in the Liberian army, fighting in the Second World War in many places. Following his discharge from the army he became a successful contractor, building diamond washing plants among other things. For ten years of the APC (All People's Congress) regime he chose to be out of the country, visiting Guinea, Mali, Senegal, Chad and Cote d'Ivoire. Since his return his career has been affected by the war. He is displaced from Sulima in the Southern Province, where he was running a fish shop, to Freetown where he stays with relatives.

He has acquired his healing knowledge throughout his life, first as a child from his parents and grandparents, and in school from a priest at the mission who used various herbs and bark as medicines. He speaks some seventeen dialects, and has learned from healers wherever he has been. He is now a highly respected healer who longs to be able to return to his home district south of Bo to resume his practice. He is, of course, practising in Freetown, but he much prefers working among his own people.

The Research Relationship

I met Pa[30] Massaquoi on the 9th of January at my first SLENTHA general meeting. Pa was the translator for me, since I spoke no Krio. He was erudite and amusing, and offered far more than literal translation, entertaining the SLENTHA members and me with his humorous interpretations. I discovered later that he managed to diffuse a potentially unpleasant situation for me. I saw him subsequently at many SLENTHA meetings--he was an active member of the executive.

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[30] "Pa" is a term of respect when addressing older men.

Table 3: Data Sources and Themes for Key Informant #2

Date	Source		The Data	
		Collaboration	Indigenous Healing Knowledge	Other
9 Jan-17 Dec	Notes from SLENTHA meetings			
9 Jan-17 Dec	Journal notes on informal meetings	-brings Sesse Koker over Apr 14 -requests intervention in SLENTHA		-note, Pa never went to Songo
19 Mar 94	Interview #1	-suggest collab bet Koker/Kamara/Turay -factors against collab-factions, regional, doctors too money consc. -internal collab-syndicate of 8 -produce meds for whole world	-family all traditional healers -history of Poro Society -treats piles, hernia, ulcers, fibroids (more in Af. Wom. -every twin/triplet a witch -eyes unequal -regional division of healers -knows 115 herbs -need for preservation, he writes (Pa Williams) -general TH diagnosis techniques -preserv: apprentices -SLENTHA: factions, jealousy Bishop/MOTL x2 -expectation of NLG x2 -nature of Freetown healers (Masiaka to FT); killers; witch guns -need for regulation -makes buckets from sheet metal--surv. strat.	-effects of war on population--provinces backbone of SL
19 Mar	Notes	"The research started in another direction today": a study of the dynamics of SLENTHA	SLENTHA-empire (MOTL); rivalry-quote -Pa's membership scenario -Pa sees Dr. Baryoh, then goes to Liberia -Bo org. of healer	

16 Sep	Interview #2	-collab with MOTL in treating piles	2 types of dry cough, curse & natural -treatment for natural -diagnosis technique (x-ray) -regional differences in herbs, strength -dosage of trad meds -Ojeh Secret Society, Nigeria -duck's allay-power to influence events -determining efficacy of cure -sacrifice for dream/wish-chanty (HJ) -fortune telling, 150 characteristics in human being -sasswood--power (social control) -sees the other side of the mountain -explanation of DEY-SLENTHA meeting -factionalism-Bo healer fraud -SLENTHA expectations of my visit $$ at first gen meeting -threat to curse me -getting wife's bracelet from the grave -dreams of his twin at warfront, WWII	-HJ's explanation of islamic folk healers controlling a person through stars

My first lengthy interview was in my apartment in Freetown on March 19, 1994. There was one other formal interview, on September 16th. In between there were many informal visits. The relationship continues on, as I left my tape recorder with my assistant to continue taping Pa's life history and the information he wants to pass on about his healing knowledge.

Implications for Collaboration

Collaboration is a serious goal for Pa Massaquoi. He has worked briefly with one medical doctor, preparing herbal remedies which the doctor then gave to his patients who suffered from piles. The arrangement was that Pa would see the patients, but would remain in the background. The doctor would give him a commission from the fee. This worked for a short while, and then the doctor stopped sending patients (Int. Sep. 16). Pa suspected some professional jealousy and unwillingness to share the fee.

> *In fact we are not against the doctors. They only feel that we are a threat to them. Even SLENTHA, I told them, whatever case we have let the doctors try first. If they cannot conquer then they pass it to us. Doctors don't refer to us. They won't. Only on rare occasions when they know they cannot do anything. They are too money conscious* (Int. Mar. 19).
>
> *Our aim is always when we have a problem to first take it to a doctor. The doctor will try; if he fails we continue. Why if you treat a patient and the patient happens to die (you haven't got a medical license) you cannot defend yourself. But a doctor will always defend himself.* (Int. 19 Mar.)

The issue of protection from charges of malpractice is raised here again. There are no regulations to control healers in Sierra Leone other than the sporadic efforts for registration by municipal authorities. This process has broken down because of the war. Although I never heard of a malpractice suit against a healer, the need for protection was an oft-cited incentive for formal collaboration and/or professionalisation. Being covered professionally by a doctor is an unequal power relationship, but it is also a short term strategy to establish legitimacy, albeit on a patient-to-patient basis. The long range strategy for placing the right to professional security in the hands of the healers will be some form of formal recognition and regulation by government or a professional society, or both.

Pa also introduced me to Dr. Sesse Koker, an organic chemist who teaches at Fourah Bay College (part of the University of Sierra Leone). They came to my apartment on April 14th. Dr. Koker has considerable experience in extracting active compounds from medicinal plants. He was trained in the States and England, and finds his present absolute lack of laboratory equipment frustrating. Pa was hopeful that Dr. Koker, Mr. Turay--the botanist/herbalist, and Osman Kamara--a pharmacist, could collaborate on isolating active compounds for processing and marketing herbal remedies. Dr. Koker was listed on the executive of SLENTHA during the first part of my research, but never attended any meetings. Pa had been trying to bring these men together for some time. Pa's goal is to *produce medicines for the whole world* from Sierra Leone.

The Preservation of Pa's Healing Knowledge

The interviews and visits with Pa Massaquoi were rich with information that he was anxious, almost driven, to share. He was, like the other healers, very disappointed that I didn't bring money for them all. I set several meeting dates with him, but he always missed interview appointments until March 19th. That day when he came to my apartment, he explained that he had decided to trust me, and to tell me everything. Subsequently he permitted me to tape three interviews, each several hours long, and has offered to let my assistant continue to tape his life history in my absence. He had to accept another disappointment as our relationship developed, and that was the fact that I could not take samples of medicinal herbs to Canada with me for analysis. It was hard for him to understand that this was not the purpose of my research. Preservation of healing knowledge is for him a serious priority, and once he saw that I was interested in collecting information from him from his own experience, he saw me as his best opportunity to preserve his own knowledge.

> *I haven't shown you anything and I might die tomorrow...die with all I have in my head. We have one case--Pa Williams is dead. He didn't write any books.*

> *He taught me eight types of herbs and I taught him eight--very important leaves* (Int. Mar. 19).

Our time together was limited by his health, although he did very well for a man of eighty, and by the demands on his time from the other displaced members of his family. He is the son of a Paramount Chief, and his responsibilities were extensive, despite his age.

He works in what he calls a syndicate in Freetown. This is a group of eight healers, four of whom are SLENTHA members. They meet frequently, often refer patients to each other, and are training apprentices. This syndicate is a strategy for preserving healing knowledge. The eight healers have shared their own knowledge with each other, and are actively training their apprentices.

Pa also keeps written records:

> *Everything, every bark, every root I use for certain diseases...and the improvement--I write about that. Of course. I keep a record. Then, whenever I have a similar case I take the same procedure and watch the patient. If that doesn't work I change my treatment. I have records of that for my children [who are also healers]* (Int. Mar. 19).

His commitment to preserving knowledge includes many strategies, sharing it with his colleagues in the syndicate, teaching his apprentices, passing on written records to his children, telling me his stories, and agreeing to continue to record his knowledge through my assistant after my departure. He believes that SLENTHA should play a role in preservation of indigenous healing knowledge as well, but sees too many problems at the moment for this to happen.

It was Pa Massaquoi who turned my attention to the complexity of SLENTHA. After the meeting with him on March 19th I noted in my journal that "the research started in another direction today," a study of the dynamics of SLENTHA, not as a potential vehicle for collaboration but as a focus in its own right. Although I had been studying SLENTHA all along, my approach shifted to a more organisational dynamic orientation at this point, as will be evident in the analysis of the participant observation data to follow.

The Nature of Pa's Healing Knowledge

In order to establish a more detailed picture of the world view of one healer in Sierra Leone, I will present several examples of the information Pa shared with me. His perspective includes pragmatism, a meticulous clinical proficiency, spirituality and magic. The excerpts below include his approach to diagnosis; a description of two conditions caused by a combination of magic and microbiology; a brief discussion of dosage determination; and a story about Pa's divining powers through his dreams. These stories were all told to me with the express purpose of preserving them and passing them on to others.

First of all, Pa Massaquoi is very methodical in his clinical examination.

> *One, the colour of the skin, the tongue, the eyes, the navel. At times you get them to urinate and you look at*

> *that. If it is children you watch the faeces. You will decide from the nasal and the faeces. With the grown-ups the urine will tell you a lot. If you cannot decide for yourself you have certain leaves that you will drop on these things, the leaves will "talk" to you. that's how we decide, because we do not have instruments to carry. In traditional healing, when we say "talk" to you it is the behaviour of the leaves. If you learn well under a traditional healer, you know exactly what I am trying to say.*

Diagnosis and treatment are closely linked in that sometimes the same condition, or one much like it, can be caused either by magic or natural agents. Distinguishing between these two sources influences treatment selection and effectiveness. Pa claims to be able to treat some of the conditions caused by magic; many other healers do not.

Dry Cough: Natural and Magical Derivation of an Illness

The condition called dry cough is not directly analogous to tuberculosis, although this is the most comparable biomedical diagnosis. The conditions as perceived from a biomedical and an indigenous healer's standpoint are not the same as evidenced from the following description taken from my interview with Pa on September 16th.

> *In Africa you have two types of dry cough: the natural dry cough which everybody carries. It comes up when you have accumulated excessive cold. That is one. But the dry cough as a curse or poison given to people in Africa will never cure.*
>
> *How do they prepare this dry cough curse? It's poison. This is how they prepare it. When they bury a corpse--the Muslim burial or traditional burial--they only have a three foot grave, while the standard grave is six feet. With this three foot grave, after three days, they cut sticks and put them through the dirt.*

> *These paw paw sticks are hollow and the top is blocked with leaves. The sticks pass through the leaves and dirt in the grave and pierce the corpse. Later they draw out the sticks and smell them. They smell the rotten human being through the holes of the cut paw paw stems to make sure the sticks are in place. Then they replace the sticks and cover them with dirt. They plant at least a dozen sticks in this way. Right into the body. Now as the body gets rot, the maggots find their way up the sticks like a pipe. When the maggots have filled the sticks and they can't go any further. The sticks are left for at least fifteen days. Then they come and collect the sticks, tying off the bottom end as well. The maggot-filled sticks are taken into the bush and dried. Then the sticks are ground into a fine powder.*
>
> *There are many other ingredients added to the powder. They also grind up bottles. They also extract the hair on the sugar cane leaves. Then there is some other plant in the bush that looks like beans--wild beans--you don't eat them. They have hair too. And this hair scratches when it comes in contact with the body. They collect some of these leaves and add them. And then you have two other leaves. I will bring them to you, I will show you the samples.*
>
> *They mix all together. When they throw that on you, the body scratches. And as you scratch the ground bottles find their way into the vein. With the maggot material it's poisonous. That's because it is contaminated with the blood from the grave. So this skin disease called "allay" is caused from this mixture. No matter how they try to cure that the patient will never recover. And that is the same powder again they use to cause the bad dry cough. They put it in your drink or food. When a person eats it then it becomes dry cough. That cannot be cured ever.*

Allay is a condition that many of the healers referred to. It is commonly known as a skin condition which results from a curse. There are varying degrees of the condition, and it also used to influence events, including a football game.

> *Duck's allay is the bad one. It is the one they prepare from the maggots they take from the grave. It splits the skin. Then they have one they use on the football field. If they see a star player they send it on him. When he gets home, rubs palm oil, the next morning he*

> *would be alright. They have another which they throw on women who refuse to fall in love with one of their members. It will trouble for some time. That one can be cured. Even that, if you met somebody with a weak constitution it will kill the person. I am against it.*
>
> *I know a member of the Ojeh Society. I am not a member. This is a society brought in by the recaptives coming from Nigeria. They are expensively dressed. Members wear flowing gowns of white, walking sticks, and follow the masquerade. They have women but the women do not masquerade. The women only sing.*
>
> *They are witch doctors. They are responsible for all these diseases--allay (skin disease) and this dry cough they put on people.*

A major criticism of traditional healers by Western-trained doctors is the inexact techniques for establishing dosage.

> *You have trees up in the Gola Forest about 9 hundred years old. I have seen a certain tree here. I extracted the bark from the root. I tried it on my very own self. The result was very poor. What I did, I doubled the dose, the dosage. I boiled the bark and left it to boil to nothing. But up country when you extract the bark--you only need say about two pounds--here [in Freetown] you have to use eight pounds of bark.*

Are you saying that the active ingredient in trees is minimal when compared to those in the Gola Forest?

> *Fact! Why, here we have the ocean, the salt water. It takes effects in the trees here. The water they soak from the soil is salty, but you and I would not notice any of this. But the Gola Forest is so far, despite all the minerals, you don't have salt up there. But from here to Masiaka, all this is the salty area. Even the mountains are salty. You don't get the salt in the Gola forest.*

Do other traditional healers know about the difference?

> *Nearly every properly trained healer knows. If you get your roots, bark or leaves from near the sea, it doesn't have that much medicinal value. But they will never tell you. They will be able to get money from you. That is why most traditional healers--we from the provinces and those from Guinea--they always bring their medicines. The barks in powder, the roots in*

> *powder. When that is finished they do more business. If they start getting bark from here they will fail.*

How do you decide the dosage of the medicine you use? How do you know for example if I brought you three patients with dry cough: one was a child, one was a woman, one was a man. How will you decide the dosage to give them? How do you decide dosage? It is different from a child, a woman, a man. Do you give them from different teas? Tell me about dosage measurement.

> *What I take to cure a child is the same as I take to cure an adult. But the dosage is when you are giving medicine to people from Europe. The white man's dosage should be very light. I had a white boss who had TB. He tried all over, he told me, an American. I don't know about dosage so I was scared, giving him bit by bit. The dose that I will give Hamidu [my assistant and interpreter] I will share it in three to give to this white man. But the result was good. From there I made my research. So I said, Ah, the white blood from our own is different. But the food that they eat from their childhood is different up to this time, and our food is different. And then the climate again. So in treating a child--African child--you always minimise the dosage. The mother has to help you a lot. This medicine you give to the child...what was the reaction? From there you know how t treat you patient. As the child cannot smoke, you boil the medicine.*

That is the treatment with the clay pipe--you boil the same medicine and the child drinks it?

> *The child drinks it and then you smoke the child with it under a cloth. You start counting one, two, three, four, five. The child is breathing the vapour from the herbs in the pot. Uncover the child; when the medicine has taken effect the child will start to cough. Then you uncover the child.*

Establishing that a cure has been effective is also an important skill. Pa has a technique which he uses after the treatment described above.

> *You test the patient by using a rag, and a seed of dry pepper. Put the old cloth in a cup with live coal, then put the dry pepper in it. Cover the head of the patient lightly. They will cough. You take the cloth off. That cough will go on for one hour. If a slimy sputum flows from their mouth, the patient is not completely cured.*

> *But if the patient takes in fresh air after this exercise, say in about 10-15 minutes, and he stops coughing, it means he is cured. If the sputum is thick and difficult to detach, it means that the patient has not been completely cured. Sometimes you are forced to cut it (the sputum). There is another way of testing. You hold both the nose and the mouth for some time. If the patient is not cured he will start to cough. If they don't it means he/she is cured.* (Int. Sep. 16)

Integrated with his knowledge of leaves, bark and roots is his special knowledge of the supernatural. Pa claims he *can see the other side of the mountain*, the side which is not visible to many of the rest of us. He was one of triplets, which is part of his source of power, and one of his eyes is smaller than the other. He is also influenced by his wife, who died in 1988, through her bracelet, which he obtained in the following manner:

> *I took this from a graveyard when they prepared it. My late wife had it. A boy twelve years of age made it and said go and give it to my aunt in Guinea. She died with this and was buried with it. After the forty days I dreamed she came to go and take this thing from the grave. I explained the dream to a senior healer, Pa Sone Fonar. He is gone back to Kamakwie. He said, well you are lucky, but I have to look into it for three days. He took me to the grave. We went to the Kingtom Cemetery. He chanted something around the grave and planted a small flower, and said, let's go. We left. The next morning he said, go and see if the flower is there. I went there and found the flower gone but I saw the impression. I returned. I told him what happened. He raised the mat he was sitting on and asked me to take the flower. I took the flower. He said the flower was brought back by the spirit. I was a Catholic for twenty-five years. I didn't believe it. The other night again I dreamed my wife came and said, go and escort me to Krootown Road Market. She said, I want to cook for you. When we went I saw myself at the grave yard. But the grave was just like a parlour. She said, let's sit down for a while. We went. This thing [bracelet] was lying on a small stool. She took it and said, wear this thing on your hand. I know why. I woke up the next day. I went to see Pa Fondar. He said, twelve o'clock today*

we are going and you will get the thing from your wife. I said, How? He said, Go home, take your bath, wear white, I shall come and pick you. He brought a taxi, the taxi put us down on Bolling Street. He paid the taxi-man. I wanted to pay him. He said, No--let's go.

The old man took a horn and placed it at the centre of the grave. A horn, the horn of a cow, placed it in the centre of the grave. He said close your eyes. I closed my eyes. He chanted and chanted, went round the grave, tapped my shoulder and asked me to open my eyes. I did and saw my wife lying on top of the grave. Then he told me to take the bracelet from her hand. That was the time I ... how to touch the dead body (corpse) and get this thing off. She had been buried over forty days! And she was as fresh as if we just dressed her. He took smelly and rubbed it on my hands and I took it. He said wear it. I wore it. He said now I am ahead of you, when I call, come and don't look behind (back). This thing I never believe. The night was dark but the place was just like when you turn your bedroom light on. Around the graveyard I could see the body. The old man went. Looking around, when I turned, she had gone down the grave. The grave as if...I thought I was in a trance. Then I turned to come. It was as if somebody was walking behind me, until I came under that cement arch and met the old man. He said, Wash in that bowl (he was carrying a bowl where he placed the herbs in a kind of liquid). Then he said, Go ahead and don't look back. He said don't join any transport until you get to your house. He took a taxi. The feeling was with me until I got home.

The next day the managing director of N.P., they owed me Le 550,000 for a job I did for them. My wife died when he was in America. He spent three months in America. When he returned I couldn't see him until after two months. That money was paid the next day. I was broke. I had just Le 1.50. How could I eat that day? I went to bank my money. By the time I came back two Lebanese were waiting for me. They ?[spent] money for me to build winter heaters that use both coal and gas and electricity. Each paid Le 300,000. They were responsible for the materials. Giant water heaters--60 U.S. gallons. I build water heaters. From that the longest I go broke is three days. I haven't slept hungry. Every month, sometimes two or three times, I dream about my wife. And for thirteen years now I know no woman. Since 1988. She had that accident. She fell on her back. My niece was a doctor here--P.C. Mott. She is now working at the UN in Geneva. She worked on her. Five years. She died the sixth year. Four years I did the cooking, I bathe her, dressed her and go out. But I should not stay out for an hour. Always I was by her

> *side. I gave up contracts which I couldn't do, unless I gave the contracts to others.*

A final story about twinship and spirituality, and Pa's latent diviner capability--dreaming of his twin sister is a source of protection, influencing his life like his wife's bracelet:

> *And do you know my sister,*[31] *up to date, for the time I became conscious of myself, we used to play together, and even the time I was in Burma, each time I dreamed of her, the next day I would be seriously sick, and the casualties that day would be heavy. I didn't take notice until the fourth operation when we crossed the Canada north, going to Norway. We fought that day--I had one in my head, if you see my nose bleeding, nothing happened. I had a severe headache. I was sent to Calcutta. We had our hospital there. I was there for three months before the bleeding stopped. The medicine the military had, they didn't bring it to any civil hospital. Then the last one, you see this scar on my foot, and then this, first, second and third degree burns. That was where nearly a whole brigade was destroyed. We were to go on a campaign. First I dreamed of my sister. Nothing happened to me. The 28th of June they said, You are booked to go. They sent the first batch. The army doesn't disclose any secrets. They wiped them out. The second batch, I volunteered. I had forgotten my dream. They threw gas in the field over night. One small ... came up and down. As it goes we see the fire. The whole place got fire like from here to Hastings. We took the preventive precaution. You opened the ... but the front was already soaking wet with gas. We didn't know. You can't smell the gas. Everything was fire. We covered ourselves with blankets. While your feet were burning you don't mind so long as your head is alright. When they took us to the hospital they wiped our skin off with the boots. The boots were melted with the skin. We were in the bush for three days before they could collect us. We chewed leaves, ate wild fruits. From that I didn't go to the front again. That was in 1943. So '44 I was resting. '45 we went and did the victory parade in Washington, D.C.*

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[31] This is one of the dead sisters from the triplets.

Pa does not distinguish between life and death as sharply as we do. In several cases during the interviews he would be speaking of his wife or twin sister and I would have to check to see if the event he was relating was before or after the death of the individual. Since he continued to communicate with them both posthumously and be tangibly influenced by them the distinction was more important to me than to him.

The Dynamics of SLENTHA: Pa's Perspective

At the beginning of the research period Pa was very involved with SLENTHA, attending all meetings of the executive and the general membership, except when he was ill. As the months went by he became disenchanted, and although he is currently the only healer listed among the professionals on the new executive, he chooses not to attend meetings, and no longer sees himself as a member of SLENTHA. He is concerned about factionalism within the organisation. He is also concerned that SLENTHA will not help with the recognition of healers and preservation of indigenous knowledge. According to Pa there is a split between healers in the Western Area (Freetown peninsula) and those up-country, past Masiaka, 47 miles east of Freetown.

> *Cutting from Masiaka, Mile 47 where you have the road branching up to the south and the north and it comes down this way, there are people you found who destroy. The strong, good healers are in the south and the east. You see the people in Kabala- (the north)-it was our great grandfathers that left those people in Kabala, so*

> *the people in Kabala and the Vai people are almost the same. We speak the same language, Mandingo* (Int. Mar. 19).

SLENTHA could be the mechanism to control the dangerous healers, according to Pa.

> *When SLENTHA has taken power and the government makes a law, anyone who throws allay [magically caused skin rash] to anyone, he goes to gaol for life. They will stop. And there are people who kill by these witch guns.*
>
> *We have to stop all things and have no knowledge of how to cure these things. Get those people under oath. Maybe when the first generation dies out, they will stop. We have to work hard* (Int. Mar. 19).

As well as the conflict in SLENTHA between some of the healers, such as Pa, and the executive, who are predominantly members of the elite Freetown society--professionals and civil servants, there is another level of conflict in SLENTHA, the personal. There was a long-standing rivalry between the Executive Director and the Chairman. The Bishop, the Chairman, is a faith healer who was trained in the United States. The Executive Director had never mentioned the Bishop in any of our several meetings. At the first general meeting in January the Bishop approached me and introduced himself, angry that the Executive Director had not brought him over to meet me. Pa was careful not to take sides in this rivalry, knowing that both the Bishop and the Director are well-established in Freetown, and that loyalties can change very quickly.

Pa's vision of SLENTHA is inclusive. He feels that the association should count as members everyone in the country, from the Chairman of the NPRC, the present government, to the sanitary man cleaning the gutters...every Paramount Chief, every tribal head, every woman and man in Sierra Leone. Not all of the membership agrees with this inclusive policy.

Another area of conflict which Pa clarified during his visits and interviews was the expectations that the SLENTHA members had of me. He told me in the first interview that I was part of the reason for the influx of the less reputable healers. Prior to my arrival in Sierra Leone, according to Pa, the director had told the healers that

> *The Canadian government is going to send two people here to send money. They all became hopeful. Then for the Symposium [planned for February 28th], the per diem for healers would start from Le 5,000 for people who are living in Freetown, Kabala Le 2,500 a day, Kailahun Le 3,000 a day for the Symposium. That sank down in everybody's mind. After you [Nancy] came that died away. Everybody went away. Everybody's face was downcast. Then we were promised to get two million, two millions dollars, from the United Nations. That also was passed on to the people. When I started to see the twilight, I told them these people are only interested in money, not the healers' welfare.*
>
> *That was the time when they saw most of the members had gone away, then they opened Songo. Then they made a mistake by taking you to Songo to see their own disgrace* (Int. Sep. 16).

Songo is a village about 34 miles from Freetown which I visited twice with the SLENTHA executive and several members. Both visits were unsuccessful from everyone's point of view in that the SLENTHA delegation was late, was welcomed only by a small number of Songo healers, and was strongly reprimanded by the Songo Chief on both occasions for not providing enough support to the village healers (Field notes, April 16, May 13). Songo healers later came for interviews at my apartment. All of them were sorcerers and diviners, the skills that Pa considered dangerous.

Similar expectations were raised about an influx of funding when my advisor, Dr. David Young, visited the country in July. Following this visit some of the healers were going to put a curse on me, which Pa discouraged.

> *I told them, Look, a stranger from afar who has come with very good intentions, even gone far to help the displaced of which you people are not thinking about. Whatever threat you people make in my absence, if anything "craw craw" set on that woman or any spot I become suspicious of, now you are in the hands of the law. And you know when I say no I mean no* (Int. Sep. 16).

These levels of conflict, once I became aware of them, added to the complexity, and the believability of what I saw in SLENTHA. The discrepancy between what I was being told by the director and what I partially sensed was confirmed first by Pa, then by other healers informally as time went by (Interview with Brenda Moses, April 6). These conflicts and expectations are not unusual in healers' associations, as recounted in Chapter two of this study. Their resolution is problematic. Pa's suggestions were idealistic, but could not be implemented. He wanted the healers' association to be more representative of the country and more inclusive of the healers. He wanted the healers to have some decision-making power. What happened instead was that in June a new executive was appointed by the director, with even less representation of healers than the earlier set of names.

Pa Massaquoi is ambivalent about SLENTHA. He is committed to the concept of a national healers association which plays a role in both collaboration and preservation of healing knowledge. Despite his hopes for the organisation, he is aware that the present model cannot achieve those goals. He takes steps on his own, encouraging entrepreneurial commercialisation of remedies, and by recording his knowledge, and by training his apprentices and cross-referral with his syndicate colleagues.

Summary and Conclusions from Key Informants' Data

These two men seem atypical of the healers that have been included in the initial section, and indeed they are in that they have considerably more formal education, and move in different circles than the indigenous healers who practice at the village level.

These people, however, are well-equipped to serve as brokers between the healers and the association, the government and the various biomedical professionals.

The study of the two men also reinforces the argument that there is no discrete body of knowledge which can be labelled as indigenous healing knowledge.

Mr. Turay approached traditional medicine from a scientific perspective, but this is not exclusive, or even predominant, as it appears at first. His Susu heritage is the framework into which he sets his botanical knowledge, using it to enhance his understanding of the herbs he has always known to exist. His scientific training provided another window through which to view what he already knew. Turay sees himself as a botanist cum healer with neither paramount. He spends more time in his role as a healer, and this is justified by the fact that he derives more of his income from his healing activities than from the College of Medicine.

Both of these men personify collaboration at a microlevel, but this collaboration is mediated by the personal experiences and formal training that both have received. They also personify collaboration at the macrolevel in that they are both involved in institutions/organisations which are experimenting with collaboration. Their perceptions of institutional collaboration are very different, however.

Pa Massaquoi operates as a cultural broker in the overlapping area between traditional and Western culture. He has integrated his educational background with many years of travel during his military career. His perception of order and organisation may be coloured by that experience, although his insistence on a voice for the healers does not reflect a sense of hierarchy as in the military. He would like to see a representative association, but described the microlevel conflict in the association as a reflection of the current macrolevel conflict in the country.

In a country the size of Sierra Leone there are no clear class distinctions: In every family, with the possible exception of some Krio families in Freetown, there are members in the government, in the professions, on the street as traders, and farmers and those who cannot support themselves and their dependents. The macro- and microlevels are interwoven through the kinship network. For this reason, although collaboration cannot yet be construed as successful at the macrolevel in Sierra Leone, we have many examples in this research, both among the key informants and the healers' interviews, where collaboration occurs on a personal, or microlevel, on a regular basis.

For Pa and Mr. Turay, ownership and preservation or transmission of knowledge is also a personal issue.

Mr. Turay is actively training other healers in his clinic in Calaba Town, and the model for the Centre for Traditional Healing includes an active experiential and formal training component.

Matthew Massaquoi has trained many apprentices in his time, plus three of his children. He continues to teach to this day, and to share his knowledge with his colleagues in the syndicate. Both Mr. Turay and Pa Massaquoi are deeply concerned about the preservation of healing knowledge, their own and that of others. The issue of preservation supersedes concepts of ownerships in the cases of Mr. Turay and Pa Massaquoi. Both of these men chose to work with me as a strategy for passing on their knowledge. Both are anxious to establish a production and marketing strategy for herbal commodities. The war has caused such severe disruption to all kin groups beyond the edge of Freetown that the apprenticeship programs and even the family networks have been disrupted, and in most cases permanently. This causes the issue of preservation and transmission to take precedence over ownership issues.

SECTION III: THE TUBERCULOSIS STUDY

Overview

These data are taken from a report written[32] for the National Leprosy and Tuberculosis Programme (NLTCP) of Sierra Leone. This is a country-wide program which provides free screening and treatment in various hospital and clinic settings in the country, as demonstrated in the map in Figure 2. and a number of international agencies in Europe. The intent of the study was to determine the actual cost to the patient of this disease including such items as tips to hospital personnel and gatekeepers, transport, cost of family relocation, fees to healers, etc. Some of the data are included in this thesis because it affords valuable insights into the patient's perspective on the spectrum of medical and healing services available in Sierra Leone.

From the patient's perspective collaboration is not an issue but cost of treatment and its effect on sequence of choice are. The study provided an opportunity to examine the range of knowledge accessed by tuberculosis patients, and to compare their experiences with biomedical and traditional systems. The data show that formal collaboration at the institutional level can be a useful strategy for reducing

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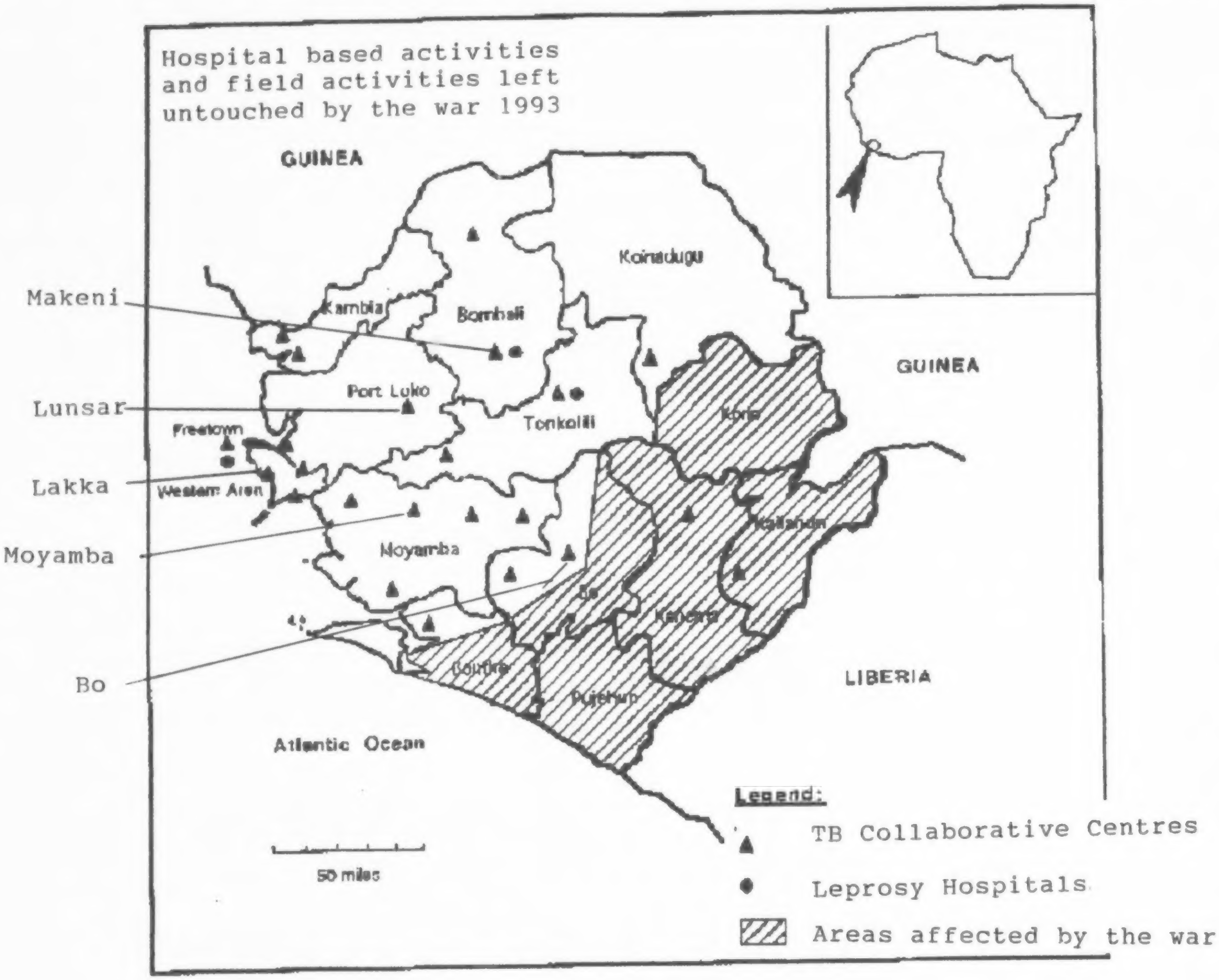
[32] I conducted this study with a research assistant from September 1, 1994 to December 1, 1994. We were able to integrate questions regarding attitude and experience with traditional healers into the research design.

Figure 2: Map of program sites for tuberculosis treatment in Sierra Leone


Hospital based activities and field activities left untouched by the war 1993
GUINEA
Koinadugu
Kambia
Bombali
Port Loko
Tonkolili
Kono
Freetown
Western Area
Moyamba
Kailahun
Bo
Kenema
Bonthe
Pujehun
GUINEA
LIBERIA
Atlantic Ocean
50 miles
Makeni
Lunsar
Lakka
Moyamba
Bo
Legend:
▲ TB Collaborative Centres
● Leprosy Hospitals
▨ Areas affected by the war

Map courtesy of NLTCP-SL

mortality and costs of TB treatment in Sierra Leone.

It must be remembered that these interviews were conducted with patients who had tuberculosis. Consequently, for the 62% who had consulted traditional healers, this option had probably failed. Ninety-four interviews were conducted, 73 with patients in clinical settings, and 20 with biomedical personnel. The place of traditional healers in the treatment continuum and the nature of indigenous knowledge about the illness are important factors in understanding the expenditure of patients' time and resources in the pretreatment phase. Traditional healers were consulted by 62% of the patients during the pretreatment phase.

Table 4: Tuberculosis Research Interview Statistics

City/Town	Patients	Staff	Other	**Total**
Freetown	12	8	2	22
Lakka	5	0	0	5
Bo	21	3	1	25
Lunsar	26	3	0	29
Makeni	3	0	0	3
Moyamba	10	0	0	10
Miscellaneous	0	0	1	1
Totals	77	13	4	94

The data fell into two categories, the pre-treatment phase and the formal treatment phase. Pre-treatment is anything that the individual did, whether or not there was a formal charge, in the period during which the illness began to affect the patient's life pattern.[33] The treatment phase begins upon admission to the NLTCP, either with admission to a hospital ward or to an outpatient programme. (See sites, Table 5.) The study confirms that the pre-treatment phase is more expensive than the treatment within the Programme despite the hidden costs of hospitalisation.

Table 5: Sites of TB Interviews

Location	Nurse	Aid	Doctor	Admin.	Misc.	Out-patient	In-patient	Total
Bo	2	1	2	0	0	7	14	26
Lunsar	0	1	0	1	0	9	17	28
Makeni	0	0	0	0	0	0	3	3
PCMH	5	-	-	1	1	0	12	19
Connaught	3	0	0	0	0	0	0	3
Lakka	0	0	0	0	0	0	5	5
Moyamba	0	1	0	3	0	2	4	10
Totals	10	3	2	5	1	18	55	94

Because of its chronic nature, tuberculosis can drain family economic reserves. The usual pattern is intermittent treatments from a variety of healers and biomedical practitioners. Treatment seeking behaviour is generally governed by the availability of money, and commitment to long-term treatment cannot be made unless it is subsidised, as it is in the case of the NLTCP hospital-based program.

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[33] Payment is not always a direct financial transaction. Often, especially in the provinces, medicines or traditional treatment are paid for in an exchange of obligations or favours over time.

Patient Profile

Many of the patients were unable to sustain consistent treatments because of lack of income (see Table 6: Patient's Economic Activity). Treatment of one sort or another is sought sporadically when there are a few hundred extra leones, and when the individual is particularly ill. When there is no money available for treatment it is interrupted, delayed or discontinued. Almost all patients in the study represented the large group of marginally employed or unemployed members of Sierra Leonean society--those most affected by the war, by the deterioration of social services and by inflation.

Table 6: Patients' Economic Profile

Activity	Number	Percentage
Employed	7	9
Retired	1	1.5
Petty trading	30	40
Farming	13	17.4
Trade	9	12
Other	2	2.7
No income	13	17.4
Total	**75**	**100.0**

Numbers can be misleading; we should not over-emphasise the "advantage" of employment. The highest salary earned by an employed patient, a teacher, was only Le 21, 850[34] per month (Cdn $53). This amount cannot support an individual much less a family--a bag of rice (50 lb.) costs approximately Le 14,000. Of the seventy-three patients in the sample, only 9% were employed.

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[34] At the time of the interviews one Canadian dollar was the equivalent of 410 leones (Le 410).

One of these men, although technically eligible for support from his job as a driver for the Department of Health, was not getting his sick benefit coverage. His name had inadvertently been left off the computer list because of a typographical error. He has appealed, but to no avail. Another man was newly retired but the bureaucratic processing for his pension had not yet been completed.

The largest number of the respondents were those who claim petty trading as their main source of income, 40%. It is likely that this figure is low, as even those who are employed often do a little business on the side. It was also discovered that several women who described themselves as petty traders had been the main support of their families, since their husbands were unemployed or earning a very small salary.

> *Now I am in the hospital I depend on my family and friends for financial help. My husband lost his job a few months ago. He was working at the City Council clearing garbage. The business I was doing helped greatly in the running of the home. Now it is difficult for all of us. I am here with the child; my husband is out of work.*[35]

Even farmers in Sierra Leone have an uncertain future because markets have been seriously disrupted by the war. Farming and petty trading go hand in hand, particularly in the rural areas. Women often sell the produce from the family farm or a small kitchen garden. There were 13 farmers in the sample, or 17.5%.

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[35] The coding system for patient interviews is suppressed to preserve the confidentiality of the participants in this portion of the study.

Twelve per cent of the participants were self-employed in various trades such as tailoring, carpentry and welding. The four individuals in the "other" category were a miner and a casual labourer who was working at clearing brush for agriculture at the time of the interview.

Once admitted to a hospital the patient was no longer contributing to the family income, except for one woman who occasionally gathered fire wood and sold it on the hospital compound[36]. In the case of the sick children, the mother or another relative was also taken out of the work force to become a care-giver to the patient during the hospital stay. Some of the mothers managed to do a little trading for a few hours a day, but most did not. The increased financial burden was felt by their families.

Eight percent of the patient sample were displaced persons from the war-affected areas. The medical costs for a few of these people were being borne by nongovernment organisations (NGOs) such as Action International Contre la Faim (France) and Cause Canada. Most people had no additional support at all, and their families were either staying with relatives or were in one of the camps for the displaced.

Some individuals had other resources such as a relative who was willing to pay their fees, send meals, and/or provide occasional pocket money and supplies such as soap and provisions.

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[36] A few of the outpatients continued to do petty trading or farming while on the treatment regime, but most were too ill to work until late in the programme.

Health Care Personnel Profile

The staff members interviewed included nurses, nurses' aides, a doctor, and several NLTCP administrative personnel, all of whom saw themselves as working in a hospital-based medical program. Several of them expressed doubts about the efficacy of traditional healing.

> Most patients who come in have tried traditional medicine for some time, in different forms, sweating, drinking. Most will later tell you that it didn't help them much. Sometimes they come with a lot of complications: difficult birthing, oedema, offensive sputum. Some of these patients do die. The only time most of these patients believe that they are TB patients is when they start coughing blood.
>
> I personally am not against traditional medicine. I think one of the problems is diagnosis, and also the fact that there are a lot of quacks professing to be herbalists. Very good healers are hard to come by. Most of those engaged in traditional healing are quacks and are in it for the money.
>
> We had a case a few years ago wherein a patient took an overdose of traditional herbs. The liver was damaged, and the patient died. This is not to say that traditional medicine is bad; I think it has to do with dosage. There is a strong belief in traditional medicine with the patients. I have seen cases where patients keep under their pillows amulets and other cultural paraphernalia which they believe protects them. There was the case of a woman who had an operation, laparotomy. When I asked the family why she kept those things under her bed they told me they are objects to drive away the witches that they think are responsible for her illness. They have a lot of belief systems for a lot of diseases. For most patients convulsions are cast by witches. For instance when a child is badly malnourished they say the child is suffering from "comeyel" (Krio for chameleon, which changes colours). Because of this rather unfortunate incidence of wrong diagnosis by the traditional healers patients die in their hands. I think they treat them for the wrong illnesses.

Staff members earned extremely low salaries (see Table 7). Typical monthly salaries are Le 10,000 for an aide, Le 13,000 for a driver, Le 17,000 for an State Enroled Nurse (S.R.N.) or (State Enroled Children's Health Nurse (S.E.C.H.N.), and Le 35,000 for a doctor. These people were all government employees in state hospitals. Health care personnel, although paid a consistent amount per month, are not able to support their families with this alone. They, too are forced to seek alternative sources of income to address expenses like food, rent and other costs of living, school fees and uniforms for their children. It is in this context that we place our interpretation of what is meant by "corruption".

Another effect of the war is that families who live outside the war zone are now housing their displaced relatives. The number of dependents [37] was as high as twenty-seven among the

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[37] In this study dependents include the immediate family, the extended family, friends and displaced relatives for whom the individual is partially or completely financially responsible.

Table 7: Biomedical Personnel Economic Profile

Code	Sex	Age	Position	Training	Salary/Month
Bo24S	F	40	Nurse	SECHN-81	Le 14,500
Bo25S	F	25	Nurse	informal	9,000
Bo26S	M	45	Doctor	?	?
CH1s	F	25	Nurse	SRN	15,000
CH2S	F	26	Nurse	SECHN,SRN	17,000
CH3S	F	27	Aide	informal	14,300
CH4S	F	27	Nurse	SECHN, SRN	15,600
CH5S	F	25	Nurse	SRN	15,000
CH6S	F	27	Nurse	SECHN	13,500
CH7S	F	25	Nurse	student, SECHN	6,500
CH8S	F	23	Nurse	student, SECHN	6,500
S1LU	M	27	Aux. Nurse	informal	39,450
S2LU	M	35	Prog. Sup.	informal	47,000
MO4S	M	38	Asst. Endemic Diseases Unit	informal	11,300
MO8S	M	60	Aide	informal	15,800
MO9S	M	32	Area Supervisor NLTCP	3 months	45,000
MO10S	M	50	Assistant NLTCP	informal	35,500

patients. Health care personnel, with their slightly higher incomes, had a higher number of dependents. The number of dependents tended to be lower in Freetown and higher in the towns close to the war zone. The reasons for this are the larger extended families in the rural areas and the proximity to the villages from which people have been forced to flee.

Pre-treatment Phase

It was learned that the most expensive part of the illness was the preliminary phase. This phase could last from one month to ten years. During this time of increasing distress patients sought symptomatic relief from a variety of sources. The onset of the disease is usually marked by fever, cough and joint pains, which is considered to be a cold by most patients. If there is a headache it is assumed to be malaria.

The first strategy for most patients, at least for adults, was self-treatment. Some may use home remedies which are in the household or medicines left over from a previous illness. Several patients had some knowledge of herbal remedies and treated themselves with lime juice, bark and other common mixtures for fever and cough.

A second strategy was consulting family and friends for advice and help. This assistance comes in the form of traditional remedies such as sweating, herbal washes and drinks. It also could be in the form of Western drugs, pills and capsules supplied from earlier treatments or purchased on the patient's behalf.

Many Western drugs can be purchased readily in Sierra Leone without a prescription (Bledsoe 1985). A prescription, however, can add prestige to the medicine in the eyes of the user, perhaps thus increasing its efficacy, but also increasing the cost. Prescriptions are considered an important part of treatment, especially in Freetown. If an injection is prescribed the prescription takes on added importance as injections are considered more likely to cure the symptoms. The placebo effect, the idea that the patient's attitude effects the cure, and not the medicine, may counterbalance the financial consideration to some extent.

The majority of the TB patients moved beyond the family and friendship circle to seek help from those whom they considered experts of one sort or another, such as traditional healers, paramedics, pharmacists and dispensers, pedlars of common medicines, nurses and nursing aides. Their expertise varies widely, but all tend to treat presenting symptoms with common remedies such as herbal drinks, or with readily available pharmaceutical tablets such as Panadol and Cafenol for pain, Chloroquine for malaria, and so on. These people also administer injections some of which undoubtedly are streptomycin, a key medication in the treatment of tuberculosis. The biomedical personnel believe that this contributes to the problem of drug resistance later on.

Although these treatments are spurred by need for symptomatic relief, they are also limited by financial constraints. Treatment courses, once defined, are often only followed partially or intermittently because of the cost. Interruption or cessation of treatment occurred when symptoms abated or money ran out. As symptoms reappeared some form of treatment would be resumed. It is not so much the cost of each individual treatment which creates financial problems, but the cumulative cost over time. Some patients have spent several hundred thousand leones on repeated visits to alternative healers and paramedical professionals before they get enroled in the subsidised TB programme. Although the following history is extreme in terms of cost (Le 200,000), it is typical of the experience of many patients.

> *In 1992 I started experiencing frequent cough. I used to smoke. When I started coughing I stopped. Then I went to the Arab hospital. They diagnosed worms and gave me treatment. I spent Le 3,000 there, and Le 200 for a card. Injections and tablets cost Le 450. I went for treatment there for 2 months. The cough persisted. Then my mother went to see a fortune teller whom we paid Le 15,000. He said it was a spell cast on me and gave me holy water which I used to wash my body and drink. According to him it was my poor wife who has cast this spell on me. I also spent money on charity to ward off this sickness. [There is a belief that if you perform certain prescribed acts of charity you can ward off evil and sickness.] This cost a lot over time, uncertain how much, some was in clothing, rice to be given away.*
>
> *In 1993 I resorted to taking traditional medicine. I had a herbalist who prepared them for me. I drank some of the concoctions. Some of the leaves were tied around my sides after they were beaten and heated over the fire. I spent Le 2,000-4,000 on every treatment, depending on what I had. I did this for two months (weekly, 9 x 3,000 = Le 27,000). There was not much improvement after this. Then I went to see a dispenser at Kissy. He said I was suffering from pneumonia and put me on treatment: streptomycin, etc. I was paying Le 15,000 a month for treatment. I took treatment for three months -- Le 45,000. Not much improvement.*
>
> *Then I went to see Dr. B. at his clinic in Kissy. I paid the consultation of Le 1,000. He sent me for an x-ray at Bathurst St. for which I paid Le 3,000. Then I took the film to him. He said I should pay him Le 100,000 for a 2 month treatment. I pleaded with him to accept Le 50,000, but he refused to accept that so I stopped seeing him.*
>
> *Then I went to see another dispenser at Fort Street, Freetown. I did 2 months with him. He gave me vitamins, streptomycin and Trazina. I spent Le 10,000 with this dispenser. I was still not normal. Then I decided to go to my home town, Rokupr, to try more native treatment. I did 10 weeks with a healer whom I*

> *paid Le 5,000. My transport back and forth was Le 3,000.*
>
> *I came back to Freetown. I visited the chest clinic at Connaught. I did an x-ray test for Le 1,500. They said it was pneumonia and put me on treatment. A nurse was administering the treatment. They asked me to pay Le 37,000 per month. I did 4 months with him, and actually paid Le 84,000. during this time our family doctor returned from overseas. He has been away from quite a long time. When my husband told him about my condition he advised him to take me to the TB and Leprosy Centre in Freetown. He referred me to a friend who works at the Centre.*
>
> *When I came to the Centre I took the sputum test and I proved positive. The friend then named all the hospitals treating TB but I chose to come here. Even if Lakka was in full swing I would have preferred to come here because I want to keep the condition of my sickness [diagnosis] quiet. This is because even friends will start making stories about you and scandalising your name.*
>
> *At Mabeseneh I paid Le 200 for the card. My husband gave Le 5,000 to a nurse. The nurse didn't ask for it; my husband gave it as a tip. I was admitted. I started treatment. Since I came to the hospital I have not bought any extra medicines. A few weeks ago I was given a drip free of charge when I complained of fever.*

This patient has sought treatment from a biomedical clinic, a fortune teller, a traditional healer, a dispenser, a medical doctor, another dispenser, another traditional healer, another medical clinic, a nurse, and a third doctor who finally referred her to the TB programme. The pre-treatment phase was two years.

When they enter a formal programme many TB patients are often already resistant to antibiotics, especially to streptomycin. Although the above patient actually knew that she had received streptomycin in the past, many do not know this, nor do they know the implications for potential resistance. Drug resistance causes a considerable waste of time, drugs and money during the later treatment phase.

According to one doctor,

> *Resistance is normally caused by quacks[38] who have no proper knowledge of the treatment. Patients do not normally tell you they have had treatment before. We are left to find out when the first phase of treatment is not successful. Then they will tell you that they have had treatment before.*

Even when Western-oriented medical personnel are consulted, misdiagnosis is common. These personnel can be nurses, aides, lab technicians, pharmacists and doctors.

> *I never saw a native healer. When my child's health started deteriorating I took her to a private practise run by a nurse from her home, doing deliveries, etc. This nurse had assisted with the delivery of Kadiatu, my daughter. When my child began to have a fever I made two visits to this nurse. No fees were paid. She prescribed medicines which I bought at Two Sisters Pharmacy for Le 3,000 on drugs. My daughter's health improved a little. Three days later after the second visit her health deteriorated again, and the high fever returned. Then I took her to Arab Hospital in Freetown. They treated her for high fever as an outpatient. I spent Le 5,000 on drugs prescribed. Later my daughter had convulsions. Then I took her to the Under Five Clinic. At the Under Five there were no fees, as I had a card. Again drugs were prescribed, and I spent another Le 3,000 on those drugs. After a few days the fever recurred. This time I took the child to Dr. B. He prescribed tablets and 5 injections--I do not know the type of medicine. I spent Le 2,000 on these drugs. The child was better for a few days, and then the fever started again. This time I returned to the same nurse who had delivered the child. She advised me to take the her to the Children's Hospital.*

It was suggested by some of the interviewees that in Freetown and Lunsar there was a tendency for practitioners including doctors to purposely misdiagnose the disease, masking it by calling it pneumonia, and retaining the patients to collect long-term high fees.

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[38] "Quacks" is the term commonly applied to the many unqualified practitioners, often calling themselves "doctors", who claim biomedical knowledge and dispense western pharmaceuticals at high prices.

A few of the people in the study were fortunate and avoided much of this pre-treatment cost by consulting a friend or family member who recognized the symptoms of coughing blood, wasting and fever, and referred the patient directly to a formal TB programme. However, most people believe that Western medicine is expensive, so entering that system is often postponed for a long time. The reality is that it is during this postponement period, when symptomatic relief is sought repeatedly, that most of the money is spent.

Traditional healing, according to the data obtained from the healers is generally, though not always, less expensive than Western medicine in terms of the cost of a visit or even a course of treatment.[39] It also incorporates psycho-social factors in a much more comprehensive fashion than other available healing systems, including Western medicine which reinforces its appeal.

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[39] The pretreatment phase was more expensive than the treatment phase, but the costs were incurred from many sources, traditional healing being only one.

Indigenous Belief Systems Regarding Causation and Treatment

The patients expressed a wide range of beliefs regarding tuberculosis and related conditions. Although most Sierra Leoneans have been treated by a traditional healer at some time in their lives, those who have been trained in Western medical techniques have distanced themselves from the traditional beliefs. Patients often hide the fact that they have seen a healer because they anticipate a negative response from the medical personnel. The result is secrecy on the part of the patient and the possibility of missing an important part of the history of the illness.

At the onset of illness patients usually treat themselves. As long as a patient believed that the condition was a cold, alternative healers were consulted for symptomatic relief. The data revealed that perception of "cold" as a source of illness is common to African and Western cultures, although the emphasis in Sierra Leonean society is much stronger. This belief is not difficult for a medically trained person to address. However, if the patient believes that the condition was caused by a curse they were not likely to approach a Western-oriented doctor or nurse at an early stage in the illness.

> *In September of this year I started coughing. I grew pale and felt some tightness in my muscles. Some people said it was my husband who has put a spell on me. Some said it was my dead father who loves me so much he wants to take me away with him (he is dead--he died in his sleep). So I went to a fortune teller who told me I will die soon. He gave me two weeks to live.*

Another was told by a fortune teller that she had been cursed, and she was not sure that she would recover. Others reflected the fear less directly, but it influenced their attitude towards treatment, and their willingness to comply with a relatively long hospitalisation.

Another example of explanations for causation is illustrated in this description of the Loko belief system.

> *In the Loko environment they say the disease is caused by leeches which suck your blood as a result of a kind of spell. So you grow pale and lose weight. You spend money seeing herbalists and fortune tellers who will tell you various things. I never knew that it was this kind of disease that I was suffering from until I came here.*

And another Temne patient:

> *Most people in the village said I shouldn't come to the hospital because they believe it has to do with traditional medicine. It was through the assistance of my mother that I came to Mabeseneh. Most believe it is wanka [a fetish usually placed on a pole in a farm field to frighten off and punish thieves]. They believed that I or someone in my family had stolen some produce from someone's farm with a wanka fetish in it. I don't know if it is so. My father had the same illness some time ago. He was cured by a healer--he never used modern medicine. He would have taken me to that same healer, but the man died some time ago. They have advised me to try the hospital, and if it doesn't work I will go back to the village and try traditional medicine.*

Most of the patients seen in the Tuberculosis Programme have not been treated successfully by native doctors. Here is an example of the experience of the mother[40] of one young TB patient.

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[40] In the case of small children with tuberculosis, the mothers were interviewed.

> *After one month of this treatment, one night my boy got so sick, complaining of pain from different parts of his body and shouting. A friend advised me to take him to a native doctor. I didn't go to the hospital that night because I wasn't sure whether the staff would be there.*
>
> *At the native doctor's house this is what happened. We paid Le 30,000 and a goat was given to the healer (costing about Le 10,000). We stayed at the medicine man's house for over a month. He fed us, though when sometimes things were bad for the healer I cooked and shared my food with him and his wife. He boiled leaves and gave them to the boy. He also sprinkled his face with holy water which contained the ink from messages (lasmami-Krio; nasi-Temne) from the Koran. After some time the shouting stopped, but the swelling on his neck remained. At this time my father came from the provinces. He is also a herbalist. He took the boy with him to the village called Kangbor (near Port Loko?). I followed them after four days. The child's throat was still swollen and getting worse. They had been treating him but the swelling continued. The child's grandfather (also a healer) then took the child to a friend of his, another herbalist. He asked for Le 2,000, but they paid him Le 1,000 only--this was to enable him to go into the bush to collect the leaves. We also gave this man a fowl (Le 1,000). He then started treating the child with the leaves. The leaves were beaten on a mortar, heated in a pot over a fire (but not cooked--no water). Then the leaves were tied with a piece of thread around the boy's neck. The swelling came down completely on one side of the neck, but only partially on the other side. The man treated him for a month, but the child was gradually wasting and getting pale. He couldn't eat.*

Here is another example of the traditional approach to treating these symptoms.

> *I tried traditional medicine for my daughter. I paid a herbalist between Le 8,000 and Le 10,000. The herbalist washed my child with boiled leaves and gave her some medicine from leaves to drink. This didn't help. We saw at least five different healers in five different places.*
>
> *The child's first symptom was a humped back. My mother sweated her then her leg got swollen. This leg was what caused us a lot of problems--it became so swollen that it burst with pus and water. For close to a year this was happening. I cannot rely on*

> *traditional medicine-my child was suffering. The hump back got healed from the native medicine, but the swelling and leakage from the leg continued. Now there is a problem with her hip bone-she cannot stand up straight. Native medicine was just sweating and the use of different leaves. Now, at the hospital, the leg is leaking only water, no more pus. It is better.*

Traditional healing beliefs about TB vary from one tribal group to another, enveloping a wider range of spirituality and mysticism than Western medicine. Perceptions of causation are not specific, but pervasive, and the treatments for symptoms are often socially meaningful, such as the holy water from the Quran verses or giving gifts to the poor. Where Western medicine generally identifies the cause of TB as separate from the actions or responsibility of the individual, traditional medicine tends to place the responsibility for illness on the past actions of the individual or a member of the family or community. This is remarkably similar to early Western ideas about TB where it was considered the wasting disease of the pure and innocent (Sontag 1977).

Traditional healing is best seen as part of a healing continuum, and not a polar opposite to Western medicine. Although only one patient told us that he was seeing a traditional healer concurrently with his hospital treatment, sixty-two percent of those interviewed had consulted healers prior to admission. All but one of the patients felt that the hospital treatment was superior to the traditional and other alternative approaches, once they had experienced a few weeks of the Programme. The immediacy of the effect of the drug therapy results made a strong impression. Many of the patients spoke of the marked improvement that they felt within a week of starting the medicines in the programme.

Hospital-based Treatment

Hospitalisation implies an abrupt adjustment to a radically different belief system. Western medicine is not well-integrated into African society yet, particularly in rural areas. It is seen as an expensive option which may not address the social causes of an illness, even if it provides a cure.

As highlighted in the Pre-treatment Phase, the major problems in the treatment of tuberculosis are poor screening and the assumption by the patients that seeking medical treatment in established programmes is expensive. The programmes, where they exist, seem to be well known and respected by health personnel and many members of the community at large. Once patients become participants in a formal biomedical programme they experience considerable symptomatic relief.

The nature of treatment for tuberculosis is long term. The initial phase in hospital is two to three months of intensive therapy, after which the patient may be discharged and treated as an outpatient for the Continuation Phase for some months. This long treatment is essential,[41] but it imposes financial hardship on the patients and their families.

> *I am deciding on what to do. I have not made up my mind yet. With the situation here [Lakka] I think I will have to go back home, raise some money and get treatment somewhere else. I am suffering here. Food is a problem for me here and I go hungry most of the time.*
>
> *It will be mental torture if I stay longer. I have no other source of income apart from my job. If I stay here longer it will be come difficult for me and my family. Presently I am worried about how they are doing and I am afraid this will affect my health. I am afraid I will have to ask the doctor to send me home as soon as possible.*

Treatment costs vary widely from one institution to another, of course, even within the NLTCP. The Programme itself is free. The programmes are subsidised, and patients are not charged for specialised drugs. They generally receive basic supplies like bedspread and blanket, and are fed two or three times daily. The per capita costs for the Treatment Phase are highest in the three government hospitals, Bo, Children's Hospital in Freetown and Moyamba. The reasons are the cost of diagnostic tests such as x-rays and sputum tests, and extra drugs, for which some institutions charge, while others do not. Here are some examples:

> *Just before my admission I paid a consultation fee of Le 3,000. A copy book: Le 150. Blood test Le 2,500; x-*

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[41] The residential nature of biomedical tuberculosis treatment may be an important factor in selection of non-residential traditional healers for some patients who wanted to continue to earn a living during the treatment.

> *ray Le 2,000. Then the doctor sent us to the Children's Ward for admission. After paying Le 1,000 admission fee we were given a bed. At the unit the doctor prescribed drugs for my daughter which I purchased at the pharmacy; Le 4,500.*
>
> *I buy extra drugs--I send people to buy them in town. I also buy syringes for injections. If we don't have a syringe for injection at Lakka we don't get treatment. Cost of needle and syringe is Le 100, so I buy one every 2 days in case the nurse comes in. (Le 1,500/month.)*
>
> *I have paid Le 12,000 for cough mixture, pills, cod liver oil, etc. since hospitalisation.*

Admission costs vary from one hospital to another. At the Children's Hospital there is an admission fee of Le 1,000. Bo Government Hospital ranges between Le 10,000 and 15,000. Moyamba is between Le 7,000 and 10,000.

> *Not everybody can afford to pay the Le 15,000 down payment at Bo that I was asked to pay. I know of patients who went away and never returned because of the money.*

The cost of the Treatment Phase at Bo Government Hospital varies from patient to patient. The doctor exercises some discretion, and some of those unable to pay the full fee may still be treated.

> *At the Bo Govt Hospital I paid for tests: sputum Le 700; x-ray Le 3,500; a doctor examined and weighed me and I was asked to pay Le 10,000 as admission fee.*
>
> *I had no money but I came to the hospital and told Dr. Muana that I am displaced from Kono. He then examined me and got me admitted. There was no charge.*

Lakka Government Hospital is exceptional. It appears to be the least expensive treatment facility, but the low cost to patients is misleading. There is no admission fee. Some meals are provided, but care is almost nonexistent. There is no regular treatment, and patients are left alone to care for themselves and each other for days and weeks at a time.

> *There is no light, no bedspread, no cups, no spoons and no lamps supplied. I bought all that I am using myself. There are also no sputum mugs, no toilet facilities. We make do with a very small palm frond thatch hut for a latrine. We are suffering here. Sometimes we don't take the treatment because of hunger. The drugs make us feel dizzy on an empty stomach.*

The costs at Lakka are hidden, but have a serious effect on the patients and their families.

The study also included two mission hospitals, those at Lunsar and Makeni. Both of these hospitals have a formal programme in conjunction with the NLTCP. The costs at these hospitals are very low in comparison to the three expensive government hospitals. Essential drugs are supplied at no cost to the patient. There are no admission fees, just a charge of Le 300 for the registration card. The only problems that patients expressed were the quality of the food and the cost of soap. Many of them spent money to supplement their diet and to buy soap. At Stocco Hospital in Makeni there is a Le 5,000 compliance fee collected upon admission of which Le 3,000 will be refunded to the patient upon completion of treatment. This has proven to be a strong incentive, contributing significantly to the success of the treatment programme.

All the patients in every setting had a few complaints, but all remained firmly convinced that the Programme was helping them. Even the patients at Lakka were optimistic.

Discussion

First of all the wide range of healing alternatives is illustrated. There is not, from a patient's perspective, a discrete distinction between practitioners (biomedical personnel) and traditional healers. There is, however a clear separation between hospital and non-hospital based treatments.

Secondly, the paramount nature of financial considerations is again underlined. The pretreatment phase is usually interrupted many times when cash is scarce.

Third, the experience of the tuberculosis patients was that the pretreatment phase cost more, and this usually included traditional healers. The patients that reach the hospital-based treatment program are those for whom traditional healing and other alternatives didn't work. The healers claim that there are many others for whom the disease was attenuated at the pretreatment phase.

The cost of traditional healers is difficult to ascertain, as a key pretreatment cost was drugs prescribed by quacks, dispensers, nurses and doctors.

Finally, these data tend to support the claim that traditional healers are more effective when treating psychogenic conditions than those caused by identifiable pathogens such as the tubercle bacillus.

Implications for Collaboration

The cost of the pretreatment phase does not necessarily indicate that traditional healers cost more,but that screening at the community level is inadequate in both biomedical and alternative spheres of practise. There would be a distinct benefit for patients if the screening programme were made nation-wide, and all healers were educated to understand when to refer patients for an x-ray or sputum test. Within the context of Pa Massaquoi's diagnostic choices, this should not be a problems, since he argues that experienced healers refer patients with blood in their sputum to biomedical personnel. A community education programme which reached all the healers and practitioners (including the medical personnel, many of whom have misdiagnosed the condition) could decrease mortality rates from TB considerably, and at the same time reduce the costs of the pretreatment phase to the patients.

SECTION IV: ANALYSIS OF PARTICIPANT OBSERVATION DATA

Overview

Participant observation data was collected in two settings: the Nongowa Clinic (also called the Banya Clinic) in Kenema, and the Sierra Leone Traditional Healers' Association (SLENTHA) in Freetown. The Nongowa Clinic provided the opportunity for research in a biomedical setting in a rural town, and the SLENTHA work the opportunity to observe an organisation which was a unique model of collaboration from the outset because of the leadership personnel, the stated objectives, and the complexity of the organisational dynamics.

This section examines the Nongowa Clinic for evidence of the range of healing knowledge within this biomedical milieu, and the overlap within the healing continuum. The data from Nongowa confirms the related conclusions drawn from the interview data in the previous sections of this chapter.

SLENTHA was originally formed in 1979. It was not formally registered as an association for traditional healers until 1992. The director's vision of the organisation has been central to its development. This vision will be examined in the context of the organisation itself and its role as a model for collaboration and preservation of indigenous healing knowledge.

Table 8: Participant-observation Data Sources and Themes

Date	Source	Collaboration	Indigenous Healing Knowledge	Other Issues
31 Jan 94	Research report	Identity in Kenema as biomedical (Nongowa Clinic)	-10 interviews with Freetown healers	
28 Feb	Research report	-my arrival stimulated events in SLENTHA -macrolevel integration in SLENTHA--professionals -BMS Turay as integration at COMAHS -examples of blurring of dichotomy	-BMS Turay's work to preserve IHK-Ms, articles -motivation for professionalisation of healers	-animal parts used in healing: monkey's feet, cow horn, leopard's claw, bone of cobra, rhino horn -official launch Ntl Health Action Plan
14 May	Research report	-potential for collaboration to undermine THPs -common core of conditions treated by both Biomedical and trad practitioners -existing practical overlap -rationale for collaboration -cost/access issues re biomedical services -Nongowa experience, pt. perspective -choice is determining factor rather than collaboration -Nongowa as *de facto* collab--Banya clan integration -interpreter Mende nurse, wife of nurse/dispenser from NC	-incentive to join SLENTHA different for older/younger healers	-illness as process, not event
6 Jan - 4 July	SLENTHA executive meeting notes	-Sama's use of trad meds for hypertensive pt. -emphasis on standardisation, becoming more scientific	-fractures healed by wrapping limb, burying it in ground -witchcraft a science -first meeting almost all professionals -visitation as strategy for increasing membership -MOTL wants professional org -	-fighting between Bishop and MOTL -problems with symp Feb 28-late, food stolen -Vera stealing money from membership fees -commission of inquiry -showed MOTL last interim report: objected to my claim that his numbers exaggerated; to being referred to as Russian-trained Krio dr. -Brenda asks for help to pull July symp off at last minute -O. Kamara wants training for THPs on nutrition, dosage regulation -labelling an issue -parliamentary procedure, sort of

11 Jan -	SLENTHA general meeting notes	-expectations from NLG-clinic, recognition for society -Dr Banya stresses need for preservation of IMK -origin of SLENTHA Sam Lewis 1979 -appointment of regional reps for FT area;79 -discussion about benefits of regional meetings, lose money? -plan visitations to all regions to inc membership -clinic concept expanded to include pharmacy -task committee, fund raising com est. 24 Mar -rag parade held in World Health Week -by Apr 5, minutes being reviewed at gen mtgs.	-want to establish clinic with herb garden to preserve plants -desire of healers to have a chance to talk at symp. -collection of money taken to help with funeral costs of member -advantages of sign over home of healers, member of SLENTHA *-exhibition planned to sell herbal remedies, 60% profit to healers, rest to SLENTHA -labelling for sale -preservation: Pa Mass wants to give knowledge to SLENTHA doesn't want to die with it	*-announced July symposium at 5 Apr mtg., committee struck -Apr 200 members listed, but only 50 fully registered (Vera) -Apr. 12 radio announcement of mtgs -July 12 set for symp -3 meetings in a row missed, suspension of memb -use of agenda as organising tool 7 Jun -sale of herbs opens up issues of labelling, preservation pushed by O. Kamara 14 June: MOTL & OK promoting internal referrals -14 June MOTL systems monitoring and engineering in SLENTHA -PROTOCOL COMMITTEE set up to monitor and ensure referrals by MOTL, OK, healer angry; MOTL appoints OK as chair of it, calls it a medical committee
28 Feb	Symposium notes			
16 Apr 13 May	Visits to Songo	-talk of collaboration	-benefits to healers of joining SLENTHA -registration -practice anywhere	problems with visits: always late, angered chiefs
15 July	Symposium notes			

3 Jan-17 Dec	Journal notes	-decision to repair Nongowa Clinic -affiliate member SLENTHA 24 Jan -meeting with S.O.S. Dr. Gibril/SLENTHA 29 Mar	-met Mr. Hemore 11 Mar; no Kenema branch of SLENTHA -collecting leaves and bark, BMS & MOTL 9 Apr -radio broadcast with MOTL on SLENTHA 15 min, 15 Apr -missed mtg with CMO, BMS and MOTL (to ICRC with Sama) -trip to Songo Apr 23 -4 May Songo chief visits apt. -13 May Songo viti #2 -14 May--SLENTHA rag parade -26 May-Songo Chief visits apt.	-difficulty creating prof. rel. with MOTL (24 Jan) -cancelled dinner with MOTL--ASB died -2 years ceremony (Ben Hirsh); 2 years ceremonies (Banya); 7 day ceremony A.S.B.; 2 wakes in Kenema; naming ceremony -began Kenema healer interviews 18 Feb (Marian & Moses) -visited Chinese doctor/wife in Kenema--unhappy

The Nongowa Clinic, Kenema

Kenema is the regional centre in the Eastern Province of Sierra Leone. Upon my arrival I chose to take on the position of voluntary administrative advisor to the Nongowa Clinic, a small 40-bed hospital in Kenema. I had been the senior nurse in charge of this hospital in 1972 when it was officially opened. In 1994 my role was to supervise renovations and re-establish administrative systems. This role helped to re-establish some old friendships and create some new professional relationships. Once it became known that I was interested in speaking with traditional healers, the staff and their families helped me to meet healers from the Kenema area, and many who had been displaced from other parts of the Eastern, Northern and Southern Provinces. I was able to raise funds for emergency drugs and rehabilitation of the clinic as well, so was seen to be making a tangible contribution with my work. The hospital is much needed as the level of care at the government hospital in Kenema is dangerous. All nongovernmental organisations (NGOs) send the civilian war wounded to Nongowa.

The Clinic has operated continuously for twenty-three years. This is in itself an achievement, given the conditions of economic collapse and civil war within the country. There are still two member of the staff on the payroll from the year of the opening, 1972. Several others of the original staff are in Kenema, and have assisted with the research to a greater or lesser extent: Moses Boima (former theatre nurse, now running a private dispensary), whose wife, Marian, served as interpreter and translator for the Kenema interviews with traditional healers; Janet McCarthy, an aide, and now a traditional birth attendant (TBA); and Edna Momoh, an aide, running her own clinic in Kpandebu village until an attack in early March, now displaced to Kenema (several of her relatives are traditional healers who were part of the interview program).

I was strongly identified with the biomedical system in Kenema, as many people remembered me from my last visit. My interviews were scheduled and interpreted by a nurse who was currently also helping her husband, a former nurse, to run a small dispensary in town. The patients in Kenema do not distinguish a dichotomy in available healing systems. They perceive choice as selecting from a range of known healers,[42] often family members. They also have a strong personal respect for the Nongowa Clinic. Dr. Banya, the founder, had made his home in Kenema until 1976. He is highly respected as a doctor, a relative and a politician who has served the Eastern Province well over his lifetime. My close association with him and the clinic worked to advantage, establishing me as another professional interested in healing. The links with the Banya clan, and my presence at many extended family ceremonies,[43] also established my link with the traditional culture.

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[42] A Chinese couple operated a clinic and dispensary in Kenema, but it was not popular because the couple were not well-liked. Personality is an important factor in choice behaviour.

It was easy to establish contacts with medical personnel through the Nongowa Clinic, and through the extended Banya family, the clan of my friend, Dr. Sama S. Banya, owner of the clinic. The Banya family includes medical, paramedical and traditional healers, leaders in the Poro and the Bundu Societies, the regional and national government and the military, and plays an integral role in almost every event.

Within the Nongowa Clinic the Banya family is represented by affinal and cognatic kin at various levels, integrating the traditional society with the clinic:

-the founder, owner, and chair of the board, Dr. Sama S. Banya
-the registration clerk/x-ray technician, Morie Ndoleh, a cousin
-Morie's partner, a nursing aide, Mary Alpha
-Hawa Banya, a nursing aide, niece
-Josephine Banya, widow of one of Dr. Banya's brothers
-Pa Momoh, the maintenance man, a relative from the home region of Kailahun, displaced to Kenema

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[43] I attended two Mende funerals, two wakes, one forty-day ceremony, one two-year ceremony (second anniversary of a death), and officiated at one naming ceremony.

-Fatu Gamanga, Board of Trustees, Dr. Banya's sister, leader of Bundu Society
-Chief S.G. Banya (Kailahun District), brother of Dr. Banya, board of trustees

The Banya family is one of the largest and most powerful in the Eastern Province.[44] Representation of this sort within a privately owned organization, presents obvious strengths and weaknesses to such a structure. Loyalty to the hospital is balanced by occasional laziness based on the assumption that a family member cannot be fired. Disputes with personnel can sometimes be arbitrated outside the hospital structure through kinship or chiefdom channels, reducing stress on the medical director, the administrative advisor and other staff members who are not family members. The medical director, a nonfamily member, faces dilemmas when the family's priorities are not consistent with his view of hospital priorities.

Although this 40-bed hospital is based on a medical model with a hierarchical structure, a doctor in charge, graduate nurses and trained nursing assistants, all staff members were born and raised in Sierra Leone, and are well aware of the traditional healing system. Here again the model of the biomedical-traditional knowledge dichotomy breaks down. Although there is no formal integration, there is clearly overlap at the informal level. I observed the following in my short time there:

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[44] One nephew, twenty-six years old at the time of the research, was based in Kenema as the Secretary of State for the Eastern Province, a minister in the NPRC government. He has since become national Secretary of Defense.

> The laboratory technician's son has sickle cell anaemia, and medical treatment for this condition is not effective. The child receives regular treatments from a traditional healer.
>
> A few of the nurses run small private practices from their homes outside of their hospital duty hours.
>
> The doctor supplied the Bundu Society leaders with tetanus vaccine before the initiation ceremonies for young girls (which include clitoridectomy).
>
> Most staff refer patients with piles (haemorrhoids) to traditional healers, since their treatment is known to be more effective.
>
> Although it is not at all officially sanctioned, it is well-known that traditional healers treat patients while they are in the Nongowa Clinic. It is easy for them to come and go, and sanctions are few--perhaps a scolding, if the healer is actually discovered doing a treatment.

Many patients come to the hospital having also been treated by traditional healers. Although some medical personnel believe that they come after traditional healing has failed, this has not been borne out consistently in my research. In Kenema patients often seek medical treatment as well as traditional treatment, sometimes in a parallel fashion for entirely different things, and sometimes for the same problems, as a strategy to "cover all the bases". Dehydrated babies with sunken fontanelles will have the traditional herbal paste on their heads. Children who have had convulsions may have a braided string around their neck made from special tree bark. Women may have a similar rope around their waists with a cowrie shell that is filled with medicinal herbs for "family planning" purposes. Sicklers will have a white paste on their joints. Those with skin conditions will have herbal pastes and powders on the affected areas. The evidence indicates a practical complementarity, not a competitive stance, at least from the patients' perspective. The Nongowa Clinic was the site of *de facto* integration rather than formal collaboration.

Fundamental to the perception of illness and healing in Sierra Leone is a **processual approach**. Illness is a frequent and often continuing factor. Most people have malaria on a regular basis and a large percentage have parasites of one sort or another, which weaken their resistance to other conditions.[45] Although they have asymptomatic periods, they are never completely cured in a biomedical sense. The biomedical approach is much more **event-oriented**, based on the assumption of a disease incident with a causative factor and identifiable curative steps which will be effective within a specific time period, closing the particular illness incident.

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[45] In a study conducted in 1971 among 59 secondary school students in nearby Segbwema, 74% had serious illnesses, 18% minor illnesses with only 8% free of disease (Gibson 1974).

In Sierra Leone even the medical personnel tend to reflect the processual approach. Dr. Conteh, the medical director at Nongowa, has a strategy which he calls the "wait and see treatment". Reflecting his profound faith in the human body to heal itself, and influenced to some extent by the almost absolute lack of resources for treatment, many patients are simply watched for a few days. They are given anti-malarial drugs, a safe place to rest, and food. This strategy has been remarkably effective.

Dr. Conteh was very interested in my work with the traditional healers. He is supportive of the idea of placing one or more traditional healers in the Nongowa Clinic to work with him, once the war has ended.

The Freetown Data: SLENTHA

My research in Kenema was cut short by the evacuation on March 14th. Once relocated in Freetown, my work with SLENTHA, which had already begun, intensified. During January, February and March I had been travelling to Freetown from Kenema to attend SLENTHA meetings, which at the time were held every two weeks (See Appendix for schedule of attendance.) I was also conducting interviews with healers in Freetown during these visits. Thirty of the thirty-four Freetown healers interviewed were members of SLENTHA. Although I was not fully aware of the implications at the time, my historical connection with the Nongowa Clinic set up expectations that I would serve as a resource for funding for SLENTHA also.

I was quite willing to do this for several months, and assisted with typing and editing project proposals for a traditional healers' clinic. This was submitted to the NPRC government, but in a war-time economy a development project such as this was not a priority. The stance of the international donors was the same: their mandate was to provide emergency relief to the displaced, and to delay all developmental funding until the economy was stable. This was very difficult to explain to the SLENTHA executive, who saw Dr. Banya and me successfully collecting donated emergency drugs and construction materials for the Kenema hospital.[46]

With the healers, however, my connection to Dr. Banya helped to establish my credibility. He is well-known in Freetown, having served as Minister of the Interior, Minister of Development and Economic Planning and Minister of Finance in a previous regime. He practices medicine in his office in Freetown, and serves as an unofficial elder statesman to the current regime and many informal organisations which are attempting to establish peace in the country.

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[46] One of the healers reported to me that SLENTHA members had been told by the executive that the medicines from the International Red Cross were really meant for SLENTHA and I had taken them to Dr. Banya's clinic instead.

Dr. Banya had passed my candidacy proposal to Dr. Taylor-Lewis, the director of SLENTHA, in September 1993, prior to my visit to Sierra Leone. It became clear after my arrival that our ensuing correspondence and Dr. Taylor-Lewis's expectation for my visit stimulated a flurry of activity in SLENTHA. My impending arrival provided the momentum for a number of events that were already on the drawing board, such as:

> *creation of a membership list with detailed information about each of the members;
>
> * planning of regional seminars and visits in all areas of the country with the objective of sharing information and increasing membership;
>
> *establishing a research base to authenticate legitimacy of the organization (SLENTHA) in the eyes of the Secretary of State for Health in order to secure future funding and governmental recognition;
>
> *strengthening the links between the healers and Western-trained physicians;
>
> *cataloguing of herbal remedies to develop a method for eventual standardization of dispensing;
>
> *cataloguing of medicinal herbs for preparation of a manuscript for use in medical college lectures;
>
> *collection of herbs for laboratory analysis of active ingredients;
>
> *establishment of a herbal pharmacy;

*establishment of a central clinic near Freetown which includes Western-trained physician(s) and traditional practitioners;

*encouragement of individual herbal kitchen gardens cultivated by each healer, and the establishment of a central herbal farm.

Planning had been started on all of these objectives. The presence of the researcher added impetus, occasional advice and expertise. Although some progress has been made, many of these goals have yet to be realised.

In January, 1994, macrolevel integration in SLENTHA was already evident. Many other professionals were full members of SLENTHA, and several were serving on the executive, including a lawyer, a demography professor, a senior civil servant in the ministry of Health, a bishop from a fundamentalist church, an instructor of herbal medicine from the Medical College of Sierra Leone and several Western-educated doctors. These professionals represented many of the mainstream institutions in the country, and the visible support of these people added credibility to the cause of achieving official recognition for traditional healing in Sierra Leone. This executive was named in 1992 when the organisation was officially registered with the government (See Appendix).

The Freetown data reveal other opportunities for tangible overlap which will extend health care services at low cost:

(1) Herbs most commonly used by THPs and thought to be most effective, e.g. those for malaria, piles, sickling crisis, and the leaves used by traditional birth attendants to induce clotting, can be analyzed by a laboratory for their active ingredients so that these medicines can be produced locally in larger quantities, field studies conducted and, dosages regulated. Once standardised supplies are tested and available these medicinal preparations can be used by medical doctors as well as traditional practitioners.

(2) Medical doctors can be educated about the cultural importance and health implications of secret society initiation practices and their implications for later health

(3) Traditional Birth Attendants should always be supplied with tetanus toxoid, a clean sharp blade and reliable disinfectant, and there should be regular in-service workshops to review procedures and learn more about prevention of infectious diseases and nutrition.

(4) A pilot cooperative clinic should be established which includes doctors and THPs who are committed to collaboration so that this process can be explored, and the lessons learned from the experiment made available to other THPs and doctors throughout the country as well as in other parts of Africa and the world.

These programs would work to enhance the repertoire of the THPs with biomedical skills. There is also the risk of subordinating traditional healing knowledge to create this paramedical orientation. There are problems with collaboration from both sides. THPs speak of the exclusivity and circumscribed nature of scientific medical knowledge, and medical doctors speak of the lack of scientific method in the more culturally oriented traditional approach.

Much of the current literature reflects a view of either medical doctors or traditional practitioners. Little has been written from the patient's point of view. However, the patients pay for health services, and they shop very carefully. In Sierra Leone patients use the full range of healing resources if they can. Most know when to consult a THP and when to go to a hospital. Many cannot go to a hospital, even when they are aware that it is the correct selection, because of distance, transport expense and cost of consultation and treatment. Despite rumours to the contrary, the TB data show that the costs associated with unsubsidised medical treatment are many times higher, on average than traditional treatment. (Another factor is that there are not enough places in the subsidised TB programme, and many are on the waiting lists.) Payment structures are also more rigid for medical doctors, who often insist on fees before examination or treatment.[47] THPs are known to be more flexible, taking payment later, in instalments, and even in-kind. The equipment that they require is much less costly than needles, syringes, drugs, sutures, operating room rental and staff salaries.

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[47] During my fieldwork I had minor surgery under a short-acting general anaesthetic (20 minutes or so). I paid Le 15,000 (Cdn$37) for x-rays, and Le 50,000 ($122) for the theatre and anaesthetic fee prior to surgery. The surgeon waived his fee when I offered to present a paper at a conference he was organising. He was also a Banya nephew. The resources to pay fees and the avoidance of the surgical charge are options not available to the average patient.

Because of the powerful position medical doctors occupy in Sierra Leonean society, relative to either THPs or patients as a group, there is little motivation to approach the health care system from the point of view of the healers or the patients. Like most Western societies, the health care system is designed for the convenience of the service delivery personnel. Macrolevel collaboration is not evident in Sierra Leone except in the few instances of the healer/botanist lecturer in the medical school and the presence of doctors on the SLENTHA executive. The dominance of the medical doctors and their active association are strong incentives for professionalisation for traditional healers.

Professionalisation of Traditional Healers: A Strategy for Microlevel Collaboration

Professionalisation of THPs has specific meaning to the healers in SLENTHA. The leadership and healers alike are consciously seeking to emulate the type of organisation that they perceive to be characteristic of the Sierra Leone Medical and Dental Association. It is seen as operating successfully to regulate and inform its membership. It was organised, in turn, after the model of the British Medical Association. The momentum for formalisation comes primarily from two sources, Dr. Taylor-Lewis, the director, and Mr.

Osman Kamara, a dispenser and politician. Over my months of observation Dr. Taylor-Lewis increasingly imposed a form of parliamentary procedure on the SLENTHA meetings. He spoke of a quorum, which was rarely achieved, and thus generally waived. He imposed an agenda which served as an organising force, as the members became used to following the same order in each meeting.

Mr. Kamara was recruited by Dr. Taylor-Lewis in April, and quickly took a position almost equal in power to Dr. Taylor-Lewis. Most of the healers treat him with respect, although some of the older ones resented his instant leadership. He speaks out at SLENTHA meetings regularly about the need to train healers in dosage regulation. He has tried to teach the healers about labelling their remedies, and encourages them to sell them. The incentive he offers for labelling is protection for trouble from the police if a patient dies from an allergy or side-effect.

Although the prospect of selling remedies appeals to the healers as an income generating strategy, labelling has not been widely successful in the association for several reasons. First, most of the member healers are nonliterate, and to design a label requires dependency on one of the biomedical people, and access to a typewriter and photocopying machine. Second, the quantities of the ingredients, and even the generic names of the plants used in the decoctions may not be known to the healer. Third, the liquid medicines have a very short shelf-life once they have been bottled, in a tropical climate with no refrigeration. Fourth, the dosage and ingredients can vary depending on where the plant was gathered, the season and whether it is fresh or powdered. Thus, about half a dozen healers showed an interest in having labels prepared, but, since their practice depends upon successful treatment, they were unwilling to take on an added risk that the medicines would quickly deteriorate in quality. Further, most of their patients are also nonliterate, and though a label adds authenticity to the remedy and even prestige to the healer in the patient's eyes, it is not a necessary element in the healing practice at present. This issue underlines the gulf that sometimes separates the biomedical and indigenous healers' perspectives.

This emphasis is not appropriate to the reality of most of the healers who cannot write. Further, most healers prepare their remedies on the spot, since there are no facilities for storage such as refrigeration. They do store herbs which have been dried and powdered for some time, but once they add water to create a decoction it is administered immediately to the patient.

Preservation and Perpetuation of Indigenous Healing Knowledge in SLENTHA

The healers want to establish a knowledge base that is shared. They want to regularize sources of medicinal plants because of price of the herbs themselves, the cost of transportation up-country to collect them, and the uneven nature of quality. They want centralized places to practice because of the lack of facilities most of them face. They want the credibility that the association can provide. They have established membership criteria which include a visit to the prospective member's site of practise by some of the executive members. A new member must be sponsored by at least one established and recognized member THP. The opinion of the community in which the THP practices is also evaluated. Reputation is considered to provide adequate regulation--those whose patients do poorly lose their patient base quickly.

During my months of observation of SLENTHA a number of organising strategies were imposed by Dr. Taylor-Lewis, some more successfully than others. Most of them were imposed in June, one month before Dr. Young's anticipated arrival. They included radio announcements in advance of general meetings to increase membership, a rule that members who missed three meetings would be suspended, and a Protocol Committee to ensure and monitor internal referrals. Mr. Kamara was appointed head of this committee which was defined by Dr. Taylor-Lewis as a *medical committee*. Several of the healers were angry that evening, arguing that they already refer patients to each other. At the June 14th general meeting Dr. Taylor-Lewis spoke of accreditation, systems monitoring and systems engineering. The meaning of these terms was not made clear, but reflect his desire to impose order on the association.

Pa Massaquoi participated in SLENTHA primarily because he wants to give his knowledge to SLENTHA, in order not *to die with it*. The mechanism for this preservation does not exist within the association at present. It was an objective in the early months when there was discussion of the establishment of a database, but this was overshadowed by the other activities and plans.

SLENTHA does work as a vehicle for perpetuating traditional healing knowledge in that the two symposia were welcome opportunities for healers to share their knowledge and skills with each other.

Implications for Collaboration

A hierarchical pattern is most commonly imposed or adopted in healers' associations, but attempts to include traditional practitioners as "junior" members of the health team are likely to fail in Sierra Leone, as they have in other African countries (Warren 1988). The healers have considerable status and prestige in their own villages, and there is little or no incentive for them to be associated as low status paramedical personnel. The more knowledgeable and experienced SLENTHA THPs are not attracted to such settings, although the younger and less experienced are. These younger healers, however, are more likely to begin to learn about the higher status biomedical approach than to continue their apprenticeship in traditional practices. They may also come to see themselves or their fellow THPs as low-level paramedicals, thus further undermining traditional healing.

SLENTHA exemplified how the dynamics of the group can overcome some of the pressure towards second class status in the association. In June when plans were being made for the July 15th symposium, Mr. Kamara suggested that only a few healers speak, since it was to be a scientific meeting. He instructed the healers were to write a speech which he would approve in advance, and then each would talk for five minutes at the symposium. When questions arose from the audience, either he or Dr. Taylor-Lewis would answer them for the healers, since they could respond scientifically. This scenario did not take place. Although a symposium planning committee had been appointed at the April 12th meeting, the actual planning for the symposium did not take place until just two days before the event. Consequently the format of this symposium was very informal and did not reflect Mr. Kamara's rigorous scientific format. It was designed primarily as a vehicle for Dr. Young to make his presentation and for some of the healers to display their skills to him and to each other.

Despite the different approaches of the executive and the membership to professionalisation within SLENTHA, the shared commitment to this strategy for recognition and economic gain is enough to sustain the coalition (Wolf 1966).

SLENTHA: A Corporate Group?

SLENTHA has some of the elements of a corporate group in that the goals are shared by all factions in the membership. The resource which is shared is indigenous healing knowledge in that the executive members who may not be healers themselves are interested in promoting its recognition (Kottak 1991). There is shared ritual in that all meetings are opened and closed with Muslim and Christian prayers. Further, the rag parade procession was a shared ritual (Rambo 1973; Appell 1976) wherein many members dressed up in unusual outfits and spent the day dancing through the streets of Freetown with drums and other instruments to raise money for SLENTHA. Rag parades are a common strategy for increasing awareness of an association.

The social support functions of SLENTHA are consistent with Lewis's definition (1991).

The group provides assistance to members when there is a death in the family and contributes to funeral expenses on the death of a member. There is a growing sense of identity reflected by the signs posted over the houses of some of the healers indicating their membership in SLENTHA. The group is moving to restrict membership through internal regulation and control. This action is inconsistent with the stated desire to extend the membership throughout the country. Limited membership implies limited access to the benefits of membership. Since no economic gain has been realised as yet, this is only a potential problem. The pragmatic solution may be tiered membership of collaborative groups, but only time will tell.

In his discussion of corporate groups, Appell refers to the possibility that resources may become controlled and perhaps traded by a few individuals within the group (1976). This concept offers an alternative model to that of appropriation, since the key informant interview with B.M.S. Turay showed that he is not an outsider to indigenous healing knowledge despite his professional status in the community. Rather than arguing that the executive of SLENTHA is appropriating the healers' knowledge, it is more useful to argue that they constitute a sub-group which has control with consent of the membership to promote the common resource, indigenous healing knowledge. Since the organisation has only existed for two years it is early to determine the emerging pattern and its eventual sustainability. At this stage SLENTHA fits Wolf's model of a corporate group in terms of single interest focus, mutual aid and ritual importance (1966). If the commitment to mutual economic gain is not met the group will either have to renegotiate its goals or dissolve.

Factionalism and Internal Rivalry

The notes from the twenty SLENTHA meetings which I attended reveal several recurrent rivalries, the most prominent of which was between Dr. Taylor-Lewis, the director, and the Bishop who was chairman. In June Dr. Taylor-Lewis recruited a new executive board (see Appendix), and the Bishop was no longer an officer. Although such rivalries are disruptive, they are common to every professional and voluntary association.

There is a potential for regional factionalism as well. Formal visits to other areas to encourage membership are part of SLENTHA's strategy. I accompanied the group on two occasions. The potential for conflict was illustrated during the two official visitation of SLENTHA to the villages of Songo and Songo Colony (two adjacent villages with different chiefs because they lie on the border of the Western area--the former Colony, and the Southern Province--the former Protectorate). The visits took place on the 26th of April and the 13th of May. On both occasions the SLENTHA delegation was several hours late in reaching the villages. The chiefs were very angry, having gathered many people together in the morning. The crowds (claimed by one chief to be a thousand) had disbanded by 2:30 in the afternoon when we arrived. The first half hour of each visit was spent by Dr. Taylor-Lewis placating the chiefs. Although the membership was expanded by several Songo healers, the atmosphere throughout both meetings remained tense.

The Songo visits resulted in one of the chiefs subsequently coming three times to my apartment. At first he wanted my assistance to help him establish a clinic in Songo for traditional healers. I referred him to SLENTHA, and then he returned to ask my assistance in obtaining support for his clinic from SLENTHA. For him a key incentive for joining was the establishment of a clinic. The chief thought that SLENTHA would help with this. Once he realised that SLENTHA did not have its own clinic, let alone resources for another, he associated with SLENTHA much less often.

In a small country like Sierra Leone conflict is generally resolved at least at a superficial level because subsequent face-to-face contact is unavoidable. Dr. Banya and Dr. Taylor-Lewis have met many times, some of the Songo healers have joined the Freetown SLENTHA group, and so on. Relationships are fluid. The tension in my relationship with Dr. Taylor-Lewis was intermittent. Several events had negative effects on the relationship. The first was my discovery that contrary to Dr. Taylor-Lewis's claims, there was no Kenema branch of SLENTHA. The second was when I had to cancel on short notice an invitation to dine with the Taylor-Lewis family because of the death of Dr. Banya's closest brother. Because of my link with the Banya clan, my place was with the family that day. Dr. Taylor-Lewis's wife was inconvenienced and he was offended. On another occasion I missed a meeting with the Secretary of State for Health as part of the SLENTHA delegation because the Kenema hospital was out of medicines and in dire need because of recent rebel attacks nearby. I went to the International Red Cross that morning on an emergency basis to obtain the medicines and have them sent to Kenema. These and other situations created tension between Dr. Taylor-Lewis and myself from time to time. Nevertheless, at his invitation we collaborated on a radio program about SLENTHA. I did eventually have dinner at his home with his family, and he shared many meals in my home. His wife visited me several times in my apartment, which was next door to his office, and owned by his brother. I have provided Dr. Taylor-Lewis with many articles, loaned him books, and done many hours of typing and drafting of proposals with him. I also served as an official representative of SLENTHA in delegations to meet the Secretary of State for Health, and to Songo. I made a speech about collaboration to the symposium of February 28th which was carried on radio and television, substantially increasing public awareness of SLENTHA. In sum, our relationship was uneven, but productive for us both. In this relationship as in others in Sierra Leone, continuing face-to-face contact is a mitigating factor in social conflict. Shortly before my departure Dr. Taylor-Lewis arranged that the furniture he had lent me would stay in my apartment so that it would be there when/if I returned.

SLENTHA's strategies for income generation

From the outset Dr. Taylor-Lewis and the healers discussed their objective of establishing a clinic for traditional healers in Freetown. As time went on the clinic concept expanded to include a herb garden for convenient supply and preservation of plants and a herbal pharmacy. None of these projects is likely to reach fruition until the economy of the country changes.

A more pragmatic strategy is the sale of herbal preparations. Although the formal methods of dosage regulation and labelling are being imposed by some of the professional executive members, the general membership is in favour of these steps to promote income from their potential products. Both symposia were characterised by healers demonstrating their expertise with particular remedies in an attempt to create a market. This was especially evident at the February 28th symposium when many healers refused to leave until they had been given an opportunity to tell the audience about their remedies.

An exhibition was planned for June in a park in downtown Freetown, to last a week. Each healer would have a booth and sell their remedies to the public. It was envisioned that the healers would retain 60% of the profits, giving 40% to SLENTHA. Because of the expense in renting the site this project did not take place as planned.

Nevertheless the motivation to market herbal remedies was a theme in every SLENTHA meeting, and much energy was spent devising strategies to accomplish this objective.

Discussion

The general acceptance of traditional healing practices in Sierra Leone was much more extensive than I had expected. Rather than a pro-active stance, it was an unselfconscious acceptance of what always been. It was not a recognition of indigenous knowledge as a separate entity.[48] There were occasional discussions of charlatans among the healers, just as doctors made reference to the quacks in their midst, again, acknowledging a continuing reality. One reason for this is the relative lack of professional control of Western-trained doctors in Sierra Leone. The doctors received their training in many countries, and their practices do not have as much common knowledge as that shared by the members of medical associations in Europe or North America. Although malpractice exists, whether by charlatans or quacks, malpractice suits are rare. Policing is conducted informally by reputation in both healing domains. Word-of-mouth referrals make or break practices of biomedical and traditional practitioners alike. Again, the personal nature of choice is illustrated.

Most people acknowledge that the range of Western-trained doctors is as wide as that of THPs, and in fact the two often overlap at the microlevel. The individual healers have drawn from a spectrum of healing knowledge,[49] rather than sustaining the distinct disciplinary boundaries practised, and indeed enforced, in Western countries. Some examples:

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[48] This contrasts with the focus on indigenous knowledge as a separate entity, as in several revitalisation movements in the Americas.

[49] See Appendix for comprehensive list of SLENTHA members and their healing skills.

*the traditional birth attendants who use stainless steel instrument kits and tetanus toxoid

*the Russian-trained Creole medical doctor who includes energy healing, balniotherapy and electromagnetism in his practice

*the traditional healer who uses natural diuretics to treat the ascites and edema of the extremities of congestive cardiac failure

*the traditional healer with the well-equipped labour room

* Dr. Banya's successful use of traditional remedy for hypertensive patients when drug therapy failed

There are several conditions which are treated by both approaches, such as malaria, simple fractures, sickle cell crisis, and piles (THPs); infectious diseases, compound fractures, ophthalmological and surgical procedures (medical doctors). These are not the only conditions by any means, but a core selection. Research in the form of clinical trials of herbal remedies may establish a tangible base for collaboration which would meet the scientific standards of government health care systems.

CHAPTER IV: OBSERVATIONS AND CONCLUSIONS

The purpose of this study was to examine themes related to the potential for collaboration between biomedical and traditional practitioners, and to identify the influence that underlying perceptions of the ownership of indigenous healing knowledge might bring to bear on this issue. The study clarifies these issues in the setting of Sierra Leone, and provides a useful framework for re-examining perceptions of appropriation and preservation of indigenous knowledge. In this context new light is also shed on the issue of macro- and microlevel collaboration. The conclusions and implications of this research are summarised below.

The Nature of Indigenous Knowledge in Sierra Leone

The concept of indigenous knowledge is a Western construct which does not accurately represent traditional healing knowledge in Sierra Leone. Indigenous knowledge is not a discrete unit, identifiable and recordable in its entirety. It is a politicised concept which has become a focus for revitalisation movements in the Americas (Keeshig-Tobias 1994) and elsewhere. It has also become a focus for academics who are committed to assisting with the process of recording as much of the information as possible.

The concept of indigenous healing knowledge is useful as an abstract construct, just as the artificial dichotomy between biomedical and indigenous healing knowledge still serves a useful purpose in academic and policy discussions. In a nonliterate society like Sierra Leone (18% literacy rate) where most of the healers are dependent upon oral transmission of knowledge and skills, formal preservation of indigenous knowledge is not an important issue. Only two healers, both literate, expressed concern about the preservation of their knowledge, and both were taking steps to write it down themselves.

The recording of indigenous knowledge by academics contributes to the goals of preservation, perpetuation and transmission of indigenous knowledge to some extent. The effectiveness of these efforts is limited, however. Accessibility to the suppliers of recorded indigenous knowledge is restricted by geographic, educational and economic factors.

Preservation, perpetuation and transmission of indigenous knowledge are all separate but related issues. Preservation is more important to outsiders such as academics; perpetuation and transmission are more important to the healers. Preservation implies a permanent method of recording knowledge; perpetuation implies guarding its cultural validity through traditional methods, and transmission means actively passing it on to others in the next generation who will apply it.

Perpetuation of knowledge was one of the healers' two common reasons for assisting me with my research. They knew that I was not recording their recipes and techniques, but that my work might result in a higher level of recognition from government, and ultimately a more formalised opportunity to transmit their knowledge. They also saw me as a direct or indirect pipeline to additional income, the establishment of a more formalised association, and the funding of projects. A future herbal clinic and farm were important objectives to them.

Indigenous healing permeates the culture in which it exists much more than biomedicine does, which is practised in designated locations under specified conditions. Indigenous healing knowledge and practice are very broad, serving social purposes far beyond the concept of "healing". For example, a major function of traditional practices is social control at the village level. This is evidenced by the diseases caused by theft of food from a neighbour's garden. Diviners often attribute illness to anti-social actions in the past, for which restitution must be made before health can be restored. The belief system in which such illnesses are couched serves as a force for social control. In other words, prevention of such illnesses is accomplished by conforming to social values and mores.

The research revealed that the repertoire of the traditional healers in Sierra Leone is wide-ranging and varied, making classification a useful, but inexact approach to defining healing knowledge. Because of the individualistic nature of traditional healers comparative categories are difficult to construct. For example, selecting herbalists as a category excludes the additional skills of many of the herbalists. Collaborative programs are often directed towards a particular category, but it is obvious from the data that even within the category of herbalism *per se* there is no definitive body of knowledge which is common to all or even most herbalists. For each traditional practitioner, healing knowledge is defined by interest, experience, locale and availability of plants. Even among the syndicate of eight healers to which Pa Massaquoi belongs there is some shared knowledge, but considerable experiential and geographically specific knowledge that cannot be directly shared with the group. Hence, internal referral is a common treatment strategy.

Not only was the wide range of knowledge within the sphere of indigenous healing knowledge confirmed, but also the variation within the biomedical sphere (Payer 1988). Although biomedicine has a more clearly identifiable formal core of common knowledge, there is a tendency towards personalisation and differentiation of each doctor's repertoire. This is due in part to medical training in diverse countries, and to the personal integration of traditional values and beliefs. The plural model of health care is much more representative than a dualistic model, although the dualistic approach is still useful as a base for policy-level discussions. On a practical level in Sierra Leone the distinction is between all hospital-based personnel and healers *per se*.

Patterns of Collaboration

Internal referral and collaboration also take place within the field of biomedicine, where one biomedically-oriented practitioner refers patients to another with complementary skills. The same occurs within the traditional healers' community.

Cross-referral (microlevel collaboration) is much more common if we expand the biomedical sector of the health care continuum to include nurses and dispensers as well as doctors. Healers also tend to refer patients to a clinic or hospital, as seen in the TB interviews, and not to a particular doctor. However, internal referrals are more common than cross-referrals, and when the latter do take place, they are more often from traditional healers to biomedical facilities than the reverse. Such cases are always individualistic. One doctor or one healer will cross-refer or consult with a specific counterpart. Such relationships are motivated as much by personal knowledge and trust, as by the need for consultation.

Discussions of collaboration between biomedical and indigenous practitioners lead inevitably to integration. During this research the distinction between the terms collaboration and integration became important in examining the potential for joint activities and commitment between biomedical and traditional healers. Collaboration is when joint action is undertaken between two separate individuals or organisations without loss of autonomy to either. Integration is when part of the knowledge base of one individual or organisation is absorbed into another. Integration is more often implemented than collaboration at the macrolevel. The research indicates that increasing the healers' repertoire of knowledge by adding skills such as oral rehydration therapy or tetanus injections does not diminish their status in the community, but increases their prestige. This is contrary to the oft-raised argument about the potentially negative effects of integrative programs; that is that the infusion of biomedical techniques will result in devaluation of the traditional knowledge base. This argument is based on an erroneous assumption of the static nature of a definable body of knowledge which constitutes indigenous healing knowledge. Expansion of the repertoire of traditional healers adds to a dynamic body of knowledge, increasing power, not decreasing it, at the community level. Such initiatives recognise the validity of the healers' experience as a base for the additional knowledge. This strategy for including the indigenous healers in the health care system empowers them. The healers in Sierra Leone, particularly in the Freetown area, are anxious to absorb biomedical skills which enhance their ability to help their patients, and thus increase their efficiency and their income. Because of their identity at the community level and the public recognition of their skills, the expansion of their knowledge base to include biomedical techniques only increases their personal prestige. Integrative programs are also beneficial nationally in that they really do contribute to improving the health care delivery system at the community level.

There is a second and less satisfactory pattern of integration. This occurs when healers are brought into the health care system as auxiliary personnel. They are taught biomedical techniques which make their procedures more compatible with national health goals. The new skills are valued, the coexisting traditional skills ignored or devalued by biomedically-oriented training personnel. This attitude is exemplified in the following statement by a medical doctor:

> I would argue that the indigenous traditional healer should be gradually replaced by the indigenous modern HCW [health care worker], until both 'traditional' and 'modern' healer become one in the same person. [Westermeyer 1977:105-6]

This attitude underlies many integrative programs. My research indicates that this is partly because of the biomedical bias, but very often also because of ignorance on the part of the doctors. Several medical doctors approached me during the course of my research and requested more information about traditional healing in order to increase their understanding of their patients and to increase their own healing repertoire.

Integrative programs can also have the effect of devaluing indigenous knowledge at the policy level, where healers become peripheral auxiliary personal with single, relatively simplistic skills, with which they become identified in the biomedical and governmental sphere. For example, traditional birth attendants become identified with their new ability, achieved through government-funded programs, to give tetanus injections. Their indigenous knowledge base, to which this useful skill has been added, is ignored by government and biomedical institutions.

Based upon my interviews, however, negative integration is not an issue in Sierra Leone at present. Most training programs have ground to a standstill for economic reasons.

Organisation of Traditional Healers: Rationale

The prime motivation for joining SLENTHA, the healers' association in Sierra Leone, is economic. This is not surprising because of the individualism among the healers. Where MacCormack (1986) and others have been concerned about an association's potential for homogenisation of the healers' knowledge, this outcome seems less likely in light of this research. The unique nature of their knowledge bases is their strength in that they rarely perceive each other as competing for the same patients and the same territory. Rivalry, although present, is not a strong enough force to prevent the cooperation which takes place within the association for joint economic objectives such as profitable projects and potential grants from government and donors. (Competition may become a factor in Freetown as displaced healers migrate from the Provinces and seek to establish new practices.)

Contrary to expectations, there was little protective secrecy of indigenous healing knowledge except in the cases of the knowledge considered the property of the secret societies or of a particular kin group (Good 1979). The general attitude was willingness to explain techniques and skills to each other and to me, with a view to increasing prestige, accessing a wider range of patients, and legitimisation of their professional status. In many cases opportunities to meet with me were sought out.

There is another pattern of collaboration at the macrolevel/institutional level. Most collaborative attempts at the institutional level are initiated by government and/or biomedically trained individuals with mixed motives, including establishment of a tax base, or control and regulation of traditional healers. To date, although some of these programs have survived for a few years, none can be declared an unqualified success. The most common reasons cited for failure are the lack of incentive for the biomedical personnel, and factionalism within the associations. Institutional or macrolevel collaboration at the policy level may not be a realistic objective. Some of the more focused attempts which expand the knowledge base of a group of healers (traditional birth attendants, for example) have been more successful.

Although some biomedical personnel are dedicated to supporting the recognition of traditional healers, their approach is often paternalistic. A few doctors take leadership positions in emerging healers' associations or the medical doctors in the national department of health give informal support to an association of healers. During my study several doctors expressed a sincere interest in learning more about traditional healing. There were two motivations: one, to understand their patients more completely, and two, to consider the possibility of expanding their own healing repertoires. Just as biomedical knowledge is inaccessible to traditional healers for institutional and educational reasons, similarly traditional healing knowledge is not accessible to biomedical practitioners. The data in this thesis were collected with a view to creating this option. The doctors who requested this information were rural practitioners, both European and Sierra Leonean, with no knowledge of or connection to SLENTHA. There is an opening here for education as a foundation for collaboration in the long term.

The power and income differential is such that few healers feel that their knowledge is recognised as equally valid as biomedical knowledge. The healers' association in Sierra Leone is dominated by a core group of biomedically-oriented professionals who define projects which have as yet no economic return. My study did indicate, however, that commercialisation of products was still worthy of consideration as a vehicle for true collaboration in the short term.

Marketing Indigenous Remedies as Collaboration

Factionalism in SLENTHA was overcome by focused efforts to select one or two preparations which have easily identifiable ingredients and a wide general market of interest to biomedical and indigenous healers alike.

Collaborative marketing of herbal preparations can be a strategy for a form of institutional collaboration, in that development of such products involves scientific knowledge and expertise to determine the active ingredients, dosage and preservation methods. A focused program which produced a few products to be marketed by everyone, may be a base for more equitable institutional collaboration. A collaborative project of this nature involving scientists from the University of Alberta and Chinese traditional healers has been funded by the Alberta Heritage Foundation for Medical Research (Pang 1986) and projects in Latin America have been conducted by Shaman Pharmaceuticals (King 1994). Solutions to the issue of compensation have not been satisfactorily developed (Greaves 1994; McGowan and Udeinya 1994). There are several models which offer a percentage of profits to various community representatives. In a face-to-face society like Sierra Leone the healers are more likely to be true partners in developing commercial enterprises. Their economic constraints have equipped them to guard their own rights very carefully. They are not naive, illiterate victims, as often portrayed in the liberal and academic literature.

Ownership and Perpetuation of Indigenous Healing Knowledge

Ownership of indigenous healing knowledge is not an issue in Sierra Leone at this point because there is little economic value or socio-political power attached to such ownership. Once commercial products have been developed, assuming that this goal is met at some future date, the issue of ownership may become central. Negotiating profits from such sales, if not properly planned at the outset, will bring the question of ownership into sharp focus, again on an individual basis in Sierra Leone.

Ownership becomes an issue only when it is linked with the concept of ethnic identity, or when economic gain is perceived to be misappropriated. For the moment neither issue pertains in Sierra Leone, and commercialisation is seen as a realistic economic strategy for a group of entrepreneurs to increase their income. It is a question of managing reality, since commercialisation of herbal remedies is inevitable.

Appropriation was not perceived as a threat, or even relevant concept in my discussions with healers. In my research I found that the healers would like to become more closely associated with doctors and felt no sense of potential appropriation. In a country with severe economic problems, the possibility of increasing family income is a profound incentive from the healers' perspective. The biomedical doctors are already among the elite, and their economic incentive for collaboration is not as strong.

The idea of ownership is blurred in the data of this study. The idea that indigenous healing knowledge belongs more to those without formal education in the Western sense than to others is misleading. The botanist with whom I worked is also clearly a traditional healer, incorporating both herbalism and ritual in his practice. The literature fails to deal with an apparent paradox such as this. It is logical that individuals who are proficient in aspects of both spheres, literate and conversant with business practices in the national marketplace, will take the lead in collaborative efforts and commercialisation of traditional remedies. Their doing so constitutes appropriation only if someone else who has access to the same knowledge experiences a sense of loss of knowledge or of income (actual or realistically projected).

Perpetuation of traditional healing knowledge remains fragmented, in that the process is also individualistic. One healer orally passes on his or her knowledge to an apprentice or family member, but this chain of knowledge is different from that passed on by another healer. The percentage of knowledge that is commonly held is unknown, but the data indicates that there is more diversity than coincidence.

Most of the healers with whom I worked, including those who were literate, were more concerned with perpetuation of their knowledge than preservation--a subtle but important difference in an economically disadvantaged, nonliterate society. Without formalised institutions for traditional healers, even the act of recording their knowledge could only serve the purposes of academics and literate healers, a very restricted audience, and therefore not a priority.

The traditional patterns of perpetuation through kin and non-kin apprenticeship have been broken by the effects of displacement from the war. This is a major concern of some of the older healers, and an incentive for joining the healers' association, particularly for those who are being displaced to Freetown. They see the association as being a potential vehicle for an alternative method of transmitting their knowledge.

Effects of the War on Indigenous Healers

The state of continuing low grade warfare and poverty have created an climate of continuing crisis in Sierra Leone. This emergency has become a sustained, long-term reality to which people have adapted to the best of their abilities. The healers, many of whom are displaced, have had to adjust to new sources of plants with different seasonal strengths, or they depend on relatives to send herbs from within the war zone. A few have given up practice altogether. Most have found that their healing knowledge has been an important source of income in an economy where several sources are necessary.

The transferability of the healing knowledge within the country is not universal; those whose knowledge is deeply grounded in a tribal belief system, such as some diviners, are limited to treating those with a similar background and belief system. With the vast numbers of displaced persons, however, the ethnic divisions which were geographical in the past have been completely disrupted, and representatives of all seventeen ethnic groups are to be found in most larger centres.

Throughout this research a recurrent theme has been the validity of the patient's perspective[50]. From this point of view the wide range of variation within both biomedical and indigenous health spheres is self-evident. Complementary and concurrent use of several practitioners is commonplace in what is a plural, not a dichotomous health care continuum. If this perspective is taken as a starting point then health care policy in the future will be designed to serve this public, and not be arranged primarily to reinforce the structure and power of the biomedical system. Collaborative models, if developed with this as a primary perspective, will also be sustainable.

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[50] It is conceivable that the term "patient" is a western construct in the same sense that biomedicine is. Indigenous healers do not describe their clients in the same way as biomedical personnel do--the implications of dependence, incapacity are not at issue.

Table 9: Conclusions

1.	Indigenous healing knowledge is a Western construct and not a discrete entity, particularly in a non-Western pluralistic health care continuum.
2.	Organisation of traditional healers and collaborative programs implies imposed classification, which in turn is reductionist. Traditional healing defies categorisation because: (a) THK is integrated into all aspects of the culture, and is largely culture-bound; (b) THK is almost entirely individualistic, a function of the transmission mechanisms within a nonliterate oral tradition; (c) The range of knowledge is extensive and non-congruent.
3.	Appropriation of indigenous healing knowledge is not a relevant issues in the setting of Sierra Leone, but perpetuation of knowledge is. The healers are happy to exploit their knowledge for commercial gain and to pass it on to others.
4.	Integration (as distinct from collaboration) takes place both successfully (as with the TBAs and tetanus injections and the ORT programs) and unsuccessfully where THPs are brought into the hospital-based system as low-status paramedical, ignoring their own knowledge base.
5.	Biomedical doctors may become more interested in collaborative programs if they receive an orientation in the methods and approaches used by traditional healers.
6.	Sustained internal warfare creates a unique environment in which all residents must develop strategies for adaptation. Commercialisation of herbal remedies is an example of such a strategy.
7.	The patient's perspective, in which all aspects of biomedicine and traditional healing are part of a single healing continuum, should be paramount in designing projects and initiatives for collaboration.
8.	National health care programs in Africa (and elsewhere) should include traditional healers in both the planning and delivery of health care.

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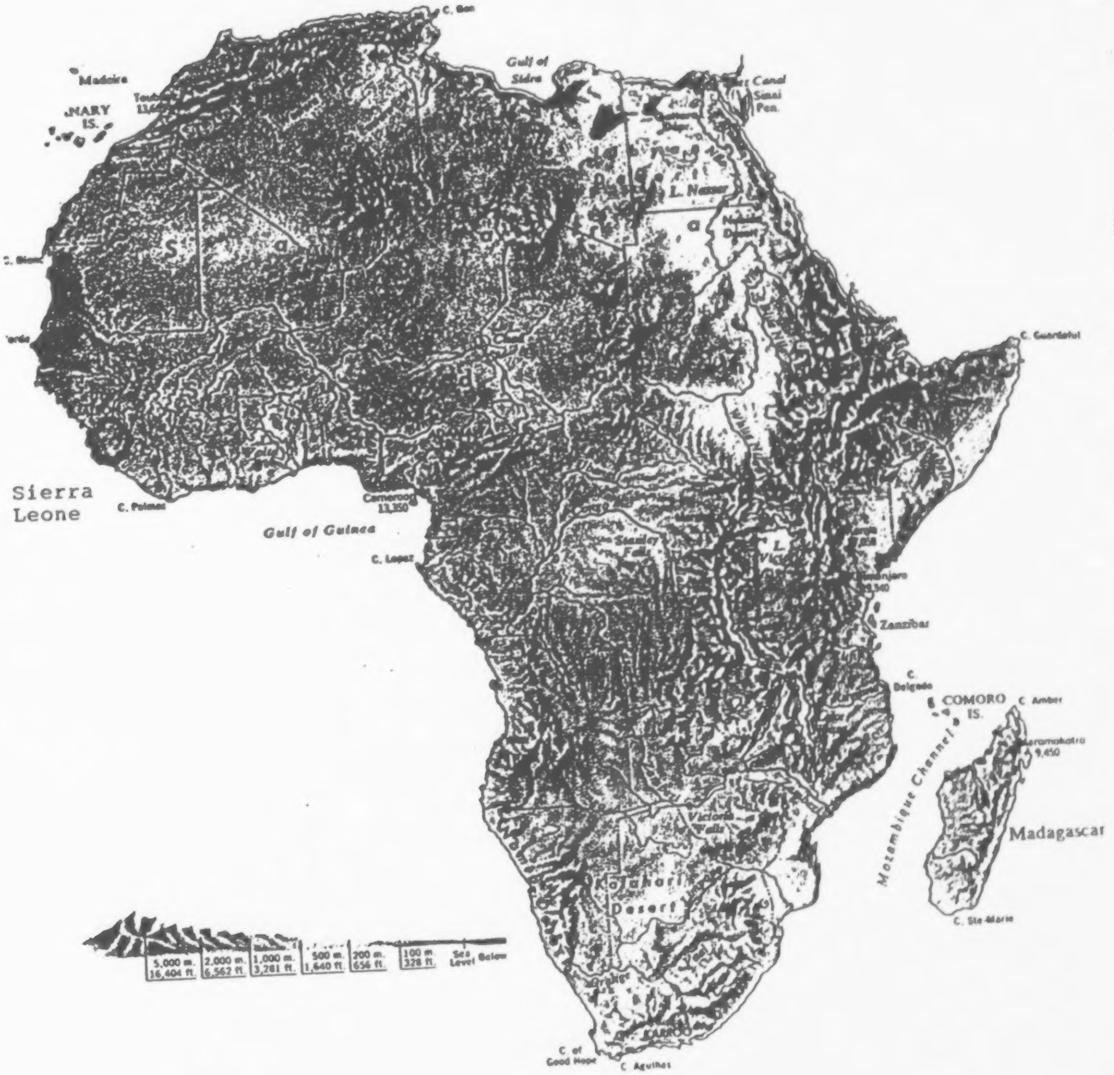
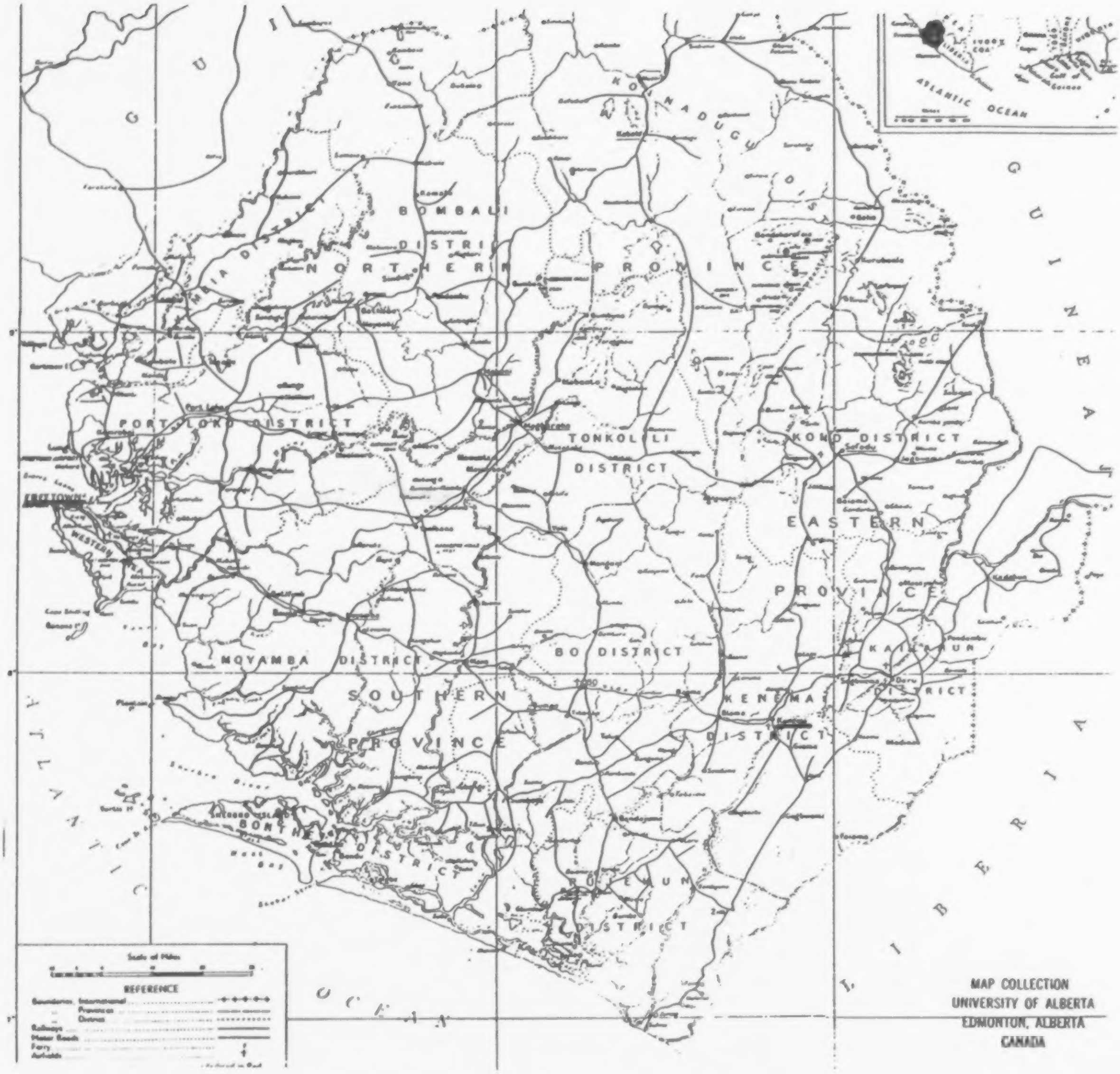
APPENDICES

1. Map of Africa
2. Map of Sierra Leone
3. Sierra Leone Historical Time Line
4. Registration Certificate, SLENTHA
5. Associate Membership Certificate, SLENTHA
6. Constitution of SLENTHA, November 1993
7. SLENTHA Executive, May 1994
8. SLENTHA Executive, June 1994
9. SLENTHA Members Skills (March 1994)
10. SLENTHA Meetings Attended
11. Comparative cost of Tuberculosis Treatment by Location

APPENDIX 1


C. Bon
Madeira
Gulf of Sidra
Canal
Sinai Pen.
NARY IS.
L. Nasser
C. Blanc
Verde
C. Guardafui
Sierra Leone
C. Palmas
Cameroon 13,350
Gulf of Guinea
C. Lopez
L. Vic
Zanzibar
C. Delgado
COMORO IS.
C. Amber
9,450
Mozambique Channel
Madagascar
C. Ste-Marie
Victoria Falls
Kalahari Desert
KARROO
C. of Good Hope
C. Agulhas
5,000 m. 16,404 ft.
2,000 m. 6,562 ft.
1,000 m. 3,281 ft.
500 m. 1,640 ft.
200 m. 656 ft.
100 m. 328 ft.
Sea Level
Below

APPENDIX 2


GUINEA
KOINADUGU DISTRICT
BOMBALI DISTRICT
KAMBIA DISTRICT
NORTHERN PROVINCE
PORT LOKO DISTRICT
TONKOLILI DISTRICT
KONO DISTRICT
FREETOWN
WESTERN
EASTERN PROVINCE
KAILAHUN DISTRICT
MOYAMBA DISTRICT
BO DISTRICT
KENEMA DISTRICT
SOUTHERN PROVINCE
SHERBRO ISLAND
BONTHE DISTRICT
PUJEHUN DISTRICT
ATLANTIC OCEAN
LIBERIA
ATLANTIC OCEAN
Scale of Miles
REFERENCE
Boundaries, International
Provinces
Districts
Railways
Motor Roads
Ferry
Airfields

MAP COLLECTION
UNIVERSITY OF ALBERTA
EDMONTON, ALBERTA
CANADA

APPENDIX 3

SIERRA LEONE HISTORICAL TIME LINE

14th Century	Portuguese traders name Serra Lyoa
	Trade, piracy, slavery
1663	First British trading company established
1787	British flag raised at Freetown; treaties Colony established for repatriated slaves
1792	Nova Scotian (American) settlers (1190)
1795	Jamaican Maroon settlers (1190)
1806	British Anti-slave Trade Act (6000+ recaptives) Missionaries begin work in coastal villages
1865	Policy to educate Africans for leadership
1884	Mama Yoko beomes Paramount Chief, unified 14 chiefdoms by 1900: Kpa Mende Confederacy
1895	Kai Lundo dies
1896	Protectorate claimed for British
1898	Hut tax rebellion
1900	Reversal of "educating Africans" policy; decline of Creole power
1924	Constitution includes reps. from Protectorate
1927	Domestic slavery abolished in S.L.
1933	Union College Bunumbu established, teacher training
1961	Independence
1967	3 military coups
1980	Hosted OAU in Freetown
1990	1 military coup

APPENDIX 4

MRDSSY/ORG/

REPUBLIC OF SIERRA LEONE

MINISTRY OF RURAL DEVELOPMENT, SOCIAL SERVICES AND YOUTH

Registration Certificate

This is to Certify that

SIERRA LEONE TRADITIONAL HEALERS ASSOCIATION (S.L.[illegible].N.T.H.A.)

is registered with the Ministry of Rural Development Social Services and Youth

As an Indigenous National Voluntary Organisation

Date 25th March, 1992

THE PERMANENT SECRETARY

Chief Social Development Officer
PERMANENT SECRETARY

TO BE RENEWED ANNUALLY

APPENDIX 5

SIERRA LEONE TRADITIONAL HEALERS ASSOCIATION
(SLENTHA)
Motto: The leaves of the trees are for the healing of the nations - Rev.22:2

Ref: ASM/5/94

18th. January, 1994.

AWARD OF ASSOCIATE
MEMBERSHIP:
MS. NANCY GIBSON

IN ACCORDANCE WITH THE CONSTITUTION OF SLENTHA UNDER THE TITLE "AFFILIATE MEMBERSHIP" I AM PLEASED TO APPRISE YOU THAT THE EXECUTIVE HAS APPOINTED YOU AS AN AFFILIATE MEMBER OF SLENTHA;

I AM CONSEQUENTLY AVAILING MYSELF AND MEMBERS OF THIS OPPORTUNITY TO CONGRATULATE YOU ON THIS AWARD.

YOU WILL IN DUE COURSE BE FURNISHED WITH YOU SPECIAL MEMBERSHIP CERTIFICATE.

YOURS FAITHFULLY,

SLENTHA

M.D.
DR. M.O. TAYLOR-LEWIS.

Contact Address: Dr. M.O. Taylor-Lewis - ~~55~~ 49 Lower Waterloo Street
Freetown - Sierra Leone - Tel: 223314/241205/223574

APPENDIX 6

CONSTITUTION OF SLENTHA

PREAMBLE:

Whereas it has been amply minifested that very many Sierra Leoneans are endowed with a natural talent and potential in the art of healing and other divers medical care (deliveries etc.) on one hand, and also that a significant sector of our community still prefers and do otherwise seek the help of the Traditional Healer on the other hand and yet again, that Traditional Healers have for very many years been actively involved in patients' care at community level, it is thus resolved to systematise the Art so as to tap, monitor, supervise them, thereby mobilising them within the community to become a national asset in health care.

In pursuance of this, The Sierra Leone Traditional HERBAL Healers' Association has been formed and registered in Sierra Leone ~~with the~~ So a to uphold, maintain and employ all and any principles of professionalism and shall concern itself primarily with the medicare and well being of the ill, disabled and any person(s) needing a divergence from conventional medicare - Allopathic medicine.

AIMS/OBJECTIVES

1. Foremostly, to administer and make available to any person(s) questing traditional (approved) medicare.
2. To serve as an approved and recognised form of medicare.
3. To standardise, systematise establish and promote recognised and approved forms and types of cure for illnesses and diseases.
4. To train, teach or furnish allowable and approved expertise and knowledge to scholars, students, trainees etc.
5. To work within the armbits of all international health authorities (WHO, UN, UNICEF, WACP/S etc) and endeavour to affiliate with other Traditional Healers Associations elsewhere.
6. To establish an approved pharmacopea of traditional herbs employed in the treatment of diseases and illnesses.
7. To conduct researches, studies seminars, symposia, conferences etc on health and any health related matters.
8. Will endeavour to uphold, observed and maintain the taboos totems and mystical sanctity of any cultural rites of members (healers, occultists) as and when an occasion so demands.
9. Will endeavour to concern itself strictly with only the healing aspects of traditional (HERBAL) medicine.
10. To produce, market and establish the safety, dosages indications mechanism of action contra-indications etc. of locally available herbs employed in the cure and treatment of man.
11. Will endeavour to cultivate and avail the nation with those herbs employed in the cure and treatment of man.
12. Will endeavour to establish approved and standardised clinics sanatoria, hospitals, dispensaries, pharmacies for traditional medicare.

13. Will endeavour to train and teach apothecaries in and for the use of traditional medicine (concoctions, potions, elixirs, pills, ointments etc).

THE CONSTITUTION

1. Shall be the only source of all the Association's Authority and delibrations and the true interpretation of it shall be vested in the Executive.

2. The General Assembly shall be the Supreme Organ of the Association.

3. The Executive Committee shall be the only and main Governing Body of SLENTHA.

4. The Advisory Committee shall be the main Counselling ~~and Arbitration~~ Body.

MEMBERSHIP

Membership of the Association shall be open to all Sierra Leonean Traditional/Herbal Healers.

None Sierra Leoneans shall be admitted under special categories as either Affiliate/Associate Members but shall however neither hold any executive posts within the Association, nor have the right to vote.

CATEGORIES OF MEMBERSHIP

There shall be the following categories of Membership:

a. Ordinary
b. Executive
c. Affiliate
d. Associate
e. Honorary

1. An Ordinary Member shall actively participate in the activities of the Association and enjoy all the privileges, opportunities and benefits of the Association based on merits and shall fulfill and observe all the financial and ethical obligations of SLENTHA.

2. An Executive Member shall be elected from among the registered and active ordinary members on the basis of merits. He/She shall observ uphold, maintain the same ethos and Constitution of SLENTHA. He/She is always answerable to the General Assembly and Executive Committee of SLENTHA.

3. AFFILIATE MEMBER

None Sierra Leoneans, Associations, Organisations etc either residen or non-resident in Sierra Leone shall be admitted on application as an affiliate member/body and shall observe the obligations/condition qualifying their membership i.e. fees, non-voting rights, free flow of informations, and shall uphold, maintain and observe this Constitution.

4. ASSOCIATE MEMBERS

Sierra Leoneans (individuals or group) living outside of Sierra Leone either tentatively or permanently and desirous of associating with SLENTHA for purely humanitarian, scientific academic and/or such like reasons, shall be admitted under this category and sh observe their financial and non-voting obligations and right stipulated by this Constitution.

5. HONORARY MEMBER

SLENTHA shall from time to time appoint/award honorary membership on any persons or groups of persons it may deem fit for such awards or appointments. However, the political or financial status of such persons or groups of persons shall not necessarily be the criteria for such awards or appointments. SLENTHA reserves the sole and exclusive right of decision in this wise. They have no voting rights

DEFINITION OF ACTIVE MEMBERSHIP

Any Ordinary/Executive who upholds, maintains and respects this Constitution is fully paid up for the current year, has participated in a minimum of Eighty percent of all general meetings and activities held within the past and current Calendar year shall be classified as an Active Member.

Such member(s) shall be eligible to vote at General Assemblies only after one Calendar Year of active Membership within SLENTHA, and be eligible for election into any of the Executive (not administrative/scientific) posts of SLENTHA.

SCIENTIFIC/ADMINISTRATIVE OFFICERS

Members/staff serving in the employs of SLENTHA on basis of academic, professional, or apprenticeship attainments or qualifications. They may/may not be members of SLENTHA and shall serve SLENTHA on those terms and conditions stipulated by the Department of Labour or other such authentic bodies operating within Sierra Leone. Their political attainment, connections, affiliations, ~~device~~ or status shall not be a criterion for appointment/employment by SLENTHA.

TERMINATION OF MEMBERSHIP

Membership of SLENTHA shall be terminated by:

1. Letter of resignation from any member through the Executive.

2. Expulsion of a member due to serious violation of SLENTHA's Constitution.

3. Any serious misdemeanour boardering on the ethos, of SLENTHA.

4. On the Unanimous recommendation of SLENTHS's Advisory Council.

5. Continuous and prolonged absence without prior notice or reasonable cause (medical, treks, sabatica etc.) at regular meetings (monthly and extra-ordinary).

6. Dereliction of duties.

STRUCTURE (ORGANS) OF THE SLENTHA

1. The General Assembly
2. The Executive Council
3. The Advisory Council
4. The Secretariat
5. Provincial Branches
6. AD-HOC/Standing Committees

GENERAL ASSEMBLY

Shall constitute the entire Association and shall be the highest power of authority of SLENTHA.

It shall elect members of the Executive and Advisory Councils of SLENTHA

It shall formulate and approve policies and work programs of SLENTHA.

It shall receive, approve or ratify quarterly, yearly and other such reports from all/any Committees.

It shall approve the monthly/yearly fiscal subscriptions and other levies of members of SLENTHA.

It shall approve/disapprove, ratify or otherwise any sanctions etc. imposed on any member(s) by either the aAdvisory or Executive Council.

It shall appoint external auditors as and when the occasion arises.

EXECUTIVE COUNCIL

- Shall implement all policies of SLENTHA approved by the General Assembly.
- Shall enforce the dictates of SLENTHA's consitution.
- Shall admit cancel, terminate all forms of memberships of SLENTHA.
- Shall conduct Bye-Elections of SLENTHA as and when the occasion arises.
- Shall execute any other duties duly relegated to it by the General Assembly of SLENTHA.
- Shall effectuate the smooth administration of SLENTHA.

COMPOSITION OF SLENTHA'S EXECUTIVES

- THE PRESIDENT
- The Chairperson/~~President~~
- The Vice Chairperson/Vice Pres.
- The Secretary-General
- The Asst. Secretary-General (1)
- The Asst. Secretary-General (2)
- The Treasurer
- The Financial Advocate (1) + (2)
- The Programmes Coordinators
- The Programs Facilitator
- Regional Directors
- Three Ex-Officios

COMPOSITION OF SLENTHA'S SCIENTIFIC ARM

The Director General
The Deputy Director General
Regional Directors
The Scientific Secretary

Coordinators: Medical
Surgical
Obs/GM
Pharmacologists
Botanists
Laboratory Tech.

Researchers
Ancillaries
Liscensing and Authorising Committee
Marketing Officer

FUNCTIONS

The President:

Shall be purely ceremonial and a distinguished public figure and graduate with pertinent administrative experience.

Shall be a Sierra Leonean with dexterity in our culture, broadminded, tolerant and sociable.

His/Her political or financial statuses shall not be a/the criterion for this office. Shall be appointed by the General Assembly for a period of Five years at an Annual General Meeting. He/She may however, be removed/ terminated from the Presidency either by a unanimous recommendation by the Executive or Advisory Council subject to ratification by a Two-Thirds majority vote of non-confidence by any General Assembly, or by letter of resignation through the Executive.

He shall execute only those duties relegated him/her either by the Executive Council or General Assembly through the Executive. He is answerable to the General Assembly, the Advisory and Executive Councils of SLENTHA and governed by the Constitution of SLENTHA.

The President of SLENTHA shall be a married person with no existing criminal records. Shall present quarterly/yearly reports of SLENTHA.

The Chairman (Person)

Shall be a distinguished public figure with administrative experience, medical/scientific background.

Shall be a married person with no existing criminal records and command/ possess an exemplary social, professional and disciplinary attitude.

Shall maintain, enforce uphold and respect the Constitution of SLENTHA.

Shall conduct all meetings both Executive and General of SLENTHA

Shall be removed/terminated by either the Executive/Advisory Council or the General Assembly by a Two-Thirds majority vote of active registered members at any general meeting of SLENTHA, or by letter of resignation through the Executive.

Shall be answerable to the General Assembly, the Executive and Advisory Councils.

The political or financial statuses of any individual will not serve as a criterion for attainment to this office.

The Director General shall be the Chairman at all times.

The Vice Chairman or Person

Shall deputise as/when necessary the Chairman(Person) or President; shal be subject to the same clauses and conditions stipulated for the Chairma in this Constitution.

The Deputy Director General shall be the Vice Chairman(person) at all times.

Special Proviso

Not withstanding the above clauses the Chairman(person) shall on certain extraordinary circumstances after consulation with the President and Vise Chairman appoint a Chairman (person) for a given situation.

The Secretary General

Shall record proceedings and deliberations of all general and executive meetings.

Shall mann the secretariat of SLENTHA.

Shall maintain the records coordinate and supervise the smooth running of all provincial branches of SLENTHA.

Shall be the forerunner of either the President/Chairman or Director General or their deputies during any meetings, travels, treks, on any official occasions of any of these officers.

Shall be an exemplary and well discilined individual with no existing or previous criminal records.

Shall on the instruction of the Chairman or President convene arrange and coordinate all meetings of SLENTHA.

Shall present quarterly and yearly reports of SLENTHA to the General Assembly.

Shall be the 'Whip' for the decorun and success of all meetings.

Shall supervise the general welfare and interests of the members of SLENTHA.

Shall maintain, uphold, respect the Constitution of SLENTHA.

Shall be answerable to the Executive/Advisory Councils and General Assembly of SLENTHA.

Shall under the aegis of the Chairman or Director General be a public representative of SLENTHA as and when requested to do so.

Shall from time to time execute and expedite such duties accentuating on the general interest and proficiency of SLENTHA relegated to him/her by the President or Chairman.

Assistant Secretary General (1)

Shall deputise the latter, assist the latter and execute/expedite all such duties meant for the overall welfare and proficiency of SLENTHA relegated to him/her from time to time either by the Executive or directly by the Secretary General. Shall be answerable to the Executive/Advisory Council/General Assembly.

Assistant Secretary General (2)

Shall be under the direct supervision of the Executive and Secretary General.

Shall be mainly responsible to direct or supervise or monitor the various official activities of all the provincial branches.

Shall be the liaison and Chief Spokesman for all provincial branches.

Shall supervise, monitor and relegate Executive/Advisory Council decisions etc. to all regional coordinators.

Shall uphold, maintain and respect the Constitution of SLENTHA and answerable to the General Assembly, Executive/Advisory Councils.

The Treasurer

Shall be the Chief Custodian of all monies, financial documents (but not assets) of SLENTHA.

Shall, not more than within forty-eight working hours deposit all sums of money received on behalf of SLENTHA into the latters authentic bank account.

Shall present quarterly and yearly financial reports of SLENTHA's finances to the Executive or General Assembly.

Aspirants/Appointees to the office of the Treasurer, shall be property holders or command a reasonable bank account within Sierra Leone.

Shall adhere strictly to the dictates of transparency and accountability and make available all financial documents to the Auditors as/when the occasion arises.

The Financial Advocates I - II

Shall be the authentic public financial mediators/negotiators/brokers for SLENTHA.

Shall negotiate, request, receive, stipulate, appeal for, endorse or otherwise all funds, aids, donations, financial assistances and commitments on behalf of SLENTHA.

Shall on no accounts disburse, expend, transact or otherwise any monies, assets etc. meant for SLENTHA on behalf of SLENTHA.

Shall be holders of properties or assets or substantial bank accounts within Sierra Leone.

Shall be married person(s).

Shall be answerable to the Executive General Assembly and Auditors.

Shall present random, quarterly and yearly reports of all such sum(s) of monies collected by them on behalf of SLENTHA.

Program Coordinators

There shall be one but not more than two for each region of the country

Shall be fluent in the language of the region under his/her aegis.

Shall not on any occasion negotiate, receive, disburse, expend or other wise any monies, properties assets or otherwise on behalf of SLENTHA unless by a unanimous decision of Executive Council.

Shall be answerable to the General Assembly Executive and Advisory Councils.

Shall work in ~~a~~ very close liaison with the regional directors and Assistant Secretary General II.

Programas/Facilitator

Shall be the Chief Organiser Convener, publicity Secretary for all symposia, workshops, Seminars, Conferences, announcements etc. on behalf of SLENTHA.

Shall observe maintain, uphold and respect the Constitution of SLENTHA.

Shall be answerable to the Executive/Advisory Councils.

Ex-Officio Members

There shall be THREE duly elected from among the members of SLENTHA at any of its General Meetings. All three shall be Traditional/Herbal Healers. They shall be deployed from time by the Executive to execute specific and special duties for the overall interests of SLENTHA.

Shall be answerable to the General Assembly, Executive and Advisory Councils.

Aside from the regular Executive and Advisory Councils, SLENTHA shall have a Scientific/Professional Arm whose duties have been defined and stipulated in the "POLICY and structure of SLENTHA".

Advisory Council

There shall be an Advisory Council of Five, married, matured Traditional/Herbal Healers appointed by the General Assembly.

It shall function mainly as an Advisory or Counselling organ empowered to make just, an unbiased recommendations on any issue(s) referred to them by the Executive or General Assembly from time to time.

SEAL/STAMP/LOGO

SLENTHA shall have an official logo, seal and **stamp.** The Seal shall be used only by the Director General on exceptional and pertinent documen (Financial/International Agreements etc) while the Stamp shall be used by the Chairman for regular or non specific documents.

Withdrawals/Signatories

In all circumstances and unless otherwise dictated by the Executive Council, the signatories to all withdrawals shall be:

The President and
The Director-General.

SIERRA LEONE TRADITIONAL HEALERS ASSOCIATION
SLENTHA
DATE
SIGN

M.D. MD
Dir[illegible]gen, SLENTHA
30/3/92.

Exec
to May 9/94

APPENDIX 7

SIERRA LEONE TRADITIONAL HEALERS ASSOCIATION

(SLENTHA)

Motto: The leaves of the trees are for the healing of the nations - Rev. 22-2

Contact address:
Dr. M.O. Taylor-Lewis
47 Waterloo Street
Freetown, Sierra Leone
Telephone: 223-574

(Copy of paper from Pa Matthew Massaquoi)

MEMBERS OF THE NATIONAL EXECUTIVE COUNCIL

1. National President - Bishop David O. Thompson
2. National Vice-president - Mr. Joseph Nathaniel Williams
3. National Secretary General - Miss Vera J. Rettew
4. National Social Secretary - Mrs. Nancy Mansaray
5. National Financial Secretary - Mrs. Edna Tucker
6. National Treasurer - Rev. Donald Davies
7. National Publicity Secretary - Mrs. Gladys Okoro-Cole
8. National Public Relations Officer- (Retd. Lt.) Mohamed Koroma

4 REGIONAL PRESIDENTS

9. Mr. T.E.A. Macauley - President Western Area
10. Mr. B.S.A. Hemore - President Eastern Province
11. Mr. Lansanah Conteh - President Northern Province
12. Mr. Mohamed Koroma - President Southern Province

THE DIRECTOR OF RESEARCH/PRODUCTION DEPARTMENT

13. Dr. M.O. Taylor-Lewis

THE SECRETARY RESEACH/PRODUCTION DEPARTMENT

14. Dr. Arnold Ryan Coker

THE ASSISTANT SECRETARY RESEARCH/PRODUCTION DEPARTMENT

15. Dr. Andrew Kosia

THE DIREDFCTOR FUND GENERATING PROJECTS DEPARTMENT

16. Mr. Sylvester A. Massaquoi

upon arrival
in SL.
Jan 94

APPENDIX 8

Second Exec

SIERRA LEONE TRADITIONAL HEALERS ASSOCIATION

(SLENTHA)

Motto: The leaves of the trees are for the healing of the nations - Rev.22:2

7th June, 1994.

Dear Sir/Madam,

Appointment as a Board Member for SLENTHA

I am pleased to apprise you that at an Executive Meeting held on on June 6th 1994, you were unanimously appointed a member of the Board of the Sierra Leone Traditional Healers' Association (SLENTHA).

Permit me on behalf of the entire Membership of SLENTHA to congratulate you on your worthy appointment and to express our fervent hope that as a true patriot and national you will devote and avail yourself always to the growth and success of SLENTHA which you will agree can be both a national and international asset contingent upon your expert direction and counselling.

The other appointees whom you may be wanting to know are:-

Alhaji Dr. Amadu Fadlu-Deen - Chairman
Mrs. Rita Dixon-Fyle LLB - Vice Chairman
Dr Mrs. Fatu Yumkella - Secretary to Board
[illegible] Edward Thomas - USL
[illegible] Nicholas Palmer - REGISTRAR ~~Dep.~~ Pharmaceut Board
Mr David Malammah-Thomas -
President SLENTHA
The Chief Medical Officer
Mr. Osman Kamara - MSC Pharm.
Pa Omafu Kamara - TMP
Mrs. Brenda Moses - TMP
Dr. M.O. Taylor-Lewis - Director SLENTHA
Mr. H.O. Massaquoi - TMP
Mrs. Majorie F. Anthony
Mr. Mustapha Turay GSDO

Please find enclosed a copy of the aims and objectives of SLENTHA whose Membership at present consists of some 500-800 Traditional

Contact Address: Dr. M.O. Taylor-Lewis - ~~55~~ 47-49 Lower Waterloo St.
Freetown - Sierra Leone - Tel: 223314/241205/[illegible]

Medical Practitioners.

We shall be pleased if you will kindly confirm your acceptance in writing to the President of SLENTHA.

This letter automatically empowers the Chairman of the Board to summon the maiden and subsequent meetings of Board Members at a time and venue of their choice.

DR. FADLU-DEEN is on TEL: 225-092 or
c/o WALPOLE Pharmacy,
Walpole Street,
Freetown.

Thanking you for your co-operation and nationalism.

Yours sincerely,

SIERRA LEONE TRADITIONAL
SLENTHA
DATE [illegible] TEL 223-574
S ASSOCIATION

Dr. H. O. T[illegible] Lewis
[illegible] SLENTHA

TEL. 223-574

APPENDIX 9

SLENTHA Membership, Range of Skills (March 1994)[7]

KARGBO, Digba	FEMALE	Dysentery, rheumatism, syphilis, severe head ache, split foot, severe shoulder ache
MOSES, Brenda	FEMALE	Kwashiolwo (banfa children), asthma, skin disease, internal pains, lumberger
SARAH	FEMALE	TBA, native gynaecologist, monkey sickness, blue boil
CONTEH, Daniel	MALE	Dysentery, malaria
JOHNSON, Henry A.	MALE	Cures all types of skin disease, hernia, diabetic
BANGURA, Yaibom Warah	FEMALE	19 years experience delivery, asthma, routine foot/hand fungus
CAULKER, Amie	FEMALE	TBA, miscarriage, internal diseases, cancer of the breast
SESAY, Deborah	FEMALE	Blockage/Urinary, born with pain, respiratory distress
SAMURA, Bunkapiie	FEMALE	TBA, general healing
COLE, Bernard	MALE	Research herbalist, tooth aches, eye trouble, chronic sour mouth, antibiotics, snake bites, dog bites, poison, tuberculosis in child and adult.
GARBER, Theresa	FEMALE	Bone specialist, worm treatment (5-6 days)
TURAY, Isatu	FEMALE	Klanka, tetanus, polio
SAMURA, Yaolie	FEMALE	TBA, gynaecologist
ANSUMANA, Isata	FEMALE	30 years experience as a Traditional Birth Attendant, splitting head, sinus, preventative birth rope, swollen children.
KAMARA, Kolleh	MALE	Okobo (impotence), witch craft, dark forces
SESAY, Ibrahim	MALE	Cures all types of worms
KARGBO, Balu	FEMALE	General gonorrhoea, dysentery, convulsions, midwifery (T.B.A.)
HOLLOWAY, Regina	FEMALE	Profuse menstrual, chest burns, malaria.
KAMARA, BALU	FEMALE	Skin disease, ear trouble (orbitis-media)
KAMARA, Maniatu	FEMALE	Urination (wet bed), sinusitis
BARRIE, Haja Fatmata	FEMALE	Jaundice, malaria, abortion. snake bites, sinus, headache, convulsion
CAMPBELL, Mabel	FEMALE	Okobo (impotence), malaria, abortion, convulsion, fibroid.
SUMA, Yaya	MALE	Abdominal abortion, bone fractures, severe headache
KARGBO, Ballay	FEMALE	Asthma, blue boil, gonorrhoea, syphilis
MOSES, Zainab	FEMALE	Bad breast (insects), blue boil, mopia
TURAY, Iye	FEMALE	TBA, swollen breast, lumbago
CONTEH, Osman	MALE	Gonorrhoea, fractures, bad stomach
BANGURA, Adama	FEMALE	Childhood intoxication

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[7] This list is incomplete, including only the members for which specialties were listed. The records reflect that the information was collected by several people, one with biomedical training, and others with familiarity with folk disease categories. Hence the mix of biomedical terminology with folk terms, many of which have no equivalent in English or biomedical lexicons because they are caused by supernatural forces.

SILLAH, Yeabu	FEMALE	Ring worm
DAVIES, Fatmata	FEMALE	Tooth ache, malaria, dysentery
BANGURA, David E.Y.	MALE	Dysentery (only)
KARGBO, Morlai	MALE	Allay (only)
KOROMA, Mabinty	FEMALE	Cord anti-baby contraceptives
MENJOR, Ndoinje	MALE	Licensed Herbalist
MANSARAY, Alpha Amadu	MALE	Licensed Herbalist
KANU, Sillah	MALE	Licensed Herbalist
KAMARA, Ansana	MALE	Licensed Herbalist
CONTEH, Finnah	FEMALE	TBA, witch craft, paralysis, bleeding, tuberculosis, sinusitis, general etc.
KAMARA, Alimamy	MALE	Bone specialist, foot/hand, severe waist pain, dysentery/fractures
CONTEH, James	MALE	Different types of sores, blue boil, dysentery
MANSARAY, Lamin	MALE	Asthma, foot with sores
KAMARA, Adama	FEMALE	Heart complaints
KAMARA, Mabinty	FEMALE	Gonorrhoea, convulsions, dysentery, syphilis
DUMBUYA, Amie	FEMALE	Epilepsy, stomach general, tuberculosis, dysentery
KOROMA, Hawa	FEMALE	TBA, difficult deliveries, still births
KOROMA, Mabinty	FEMALE	Okobo (impotence), hump back, T.B.A. (delivered a dead woman), blue boil, convulsion
MANSARAY, Mabinty	FEMALE	TBA (delivery)
LEBBIE, Isatta	FEMALE	Hiccup (only)
KAMARA, Mabinty	FEMALE	Witlar (finger pains), nasal cavities, blue boil, sinusitis in children
KARGBO, Yanken	FEMALE	Rheumatism, hiccup
MANSARAY, Kadiatu	FEMALE	Tetanus and dysentery
SESAY, Fanta	FEMALE	Different stomach pains, acute dysentery, waist pain
LEBBIE, Hawa	FEMALE	Jaundice, malaria, side pain
DUMBUYA, Alpha Musa	MALE	Severe waist pain, dry dysentery, stool with blood
LANSANA, Solomon	MALE	Pile (one anus comes out), blue boil/facing cloth
KARGBO, Edward	MALE	Allay, blue boil, whooping cough
CONTEH, Fatu	FEMALE	Okobo (infertility), tarbata, TBA/delivery and gonorrhoea
KOROMA, Umaru	MALE	Malaria and stomach pains
BANGURA, Alpha	MALE	Hiccup, bed sores malaria, gonorrhoea
BANGURA, Sarah	FEMALE	Bleeding, malaria and tuberculosis
SAMUEL, Esther	FEMALE	TBA, delivery
ROBERT, Marie	FEMALE	Malnutrition, poison
KOROMA, David	MALE	Poison, worm treatment, fungus of the foot, chronic malaria and fractures
CONTEH, Abu	MALE	Soothe sayer, treats madness
KANU, Foday	MALE	Malaria and dysentery

FOFANA, Adama	FEMALE	Malaria, oedema in pregnancy, oncho, weak bladder, general abdominal pain, complication, amenorrhea, tertial headache, convulsion, vaginal discharge, itching, rheumatism, dubo boils, fibroid barren, TBA.
BANGURA, Zainab	FEMALE	Measles, dysentery and heart complaints
COLE, Nancy	FEMALE	Malaria, dysentery, heart complaints
FADIKA, Fatmata	FEMALE	Headache and asthma
KOROMA, Yedbu	FEMALE	Nasal cavities and bad breath
BANGURA, Yai Mama	FEMALE	Swollen eye
KARGBO, Kadiatu	FEMALE	Heart complaints
KARGBO, Salimatu	FEMALE	Difficult menstruation, worms of all types
CONTEH, Sorie	MALE	Remove witch gun cartridges (witch craft), craziness, side pains, general
SESAY, Sento	FEMALE	General Herbalist
MAMMY	MALE	Bone specialist
SMITH, Pa Joe	MALE	Bone specialist
BLACKIE, Pa Luseni	MALE	Snake bites
NALLO, Momo		Growth, poison and gonorrhoea
KAMARA, Santigie	MALE	Stomach problems, gonorrhoea, malaria and dentistry
SMITH, Fadia		Malaria, skin, piles.
KAMARA, Marie	FEMALE	Bone, syphilis, weak bladder, midwifery.
TUCKER, H.B.	MALE	Dentistry
SESAY, Yegbeh	FEMALE	Malaria, TBA
NALLO, Sheku Idrisa	FEMALE	Hernia, gonorrhoea, elephantiasis, leprosy, general, goitre, weak bladder, abdominal pain, epileptic fits, headache of all types, eye problems (cowry shells), tuberculosis
GBONDO, Dominic	MALE	Witch craft and herbalist
SHERIFF, Alhaji Sheku	MALE	Witch craft and herbalist
KOROMA, Gbessay		Witch craft and herbalist
CONTEH, Iye		Gynaecologist
KOROMA, Salamatu		Gynaecologist
YAMAH, Mamie	FEMALE	Tertial headache, malaria, amenorrhea, impotence (okobo), common colds, threatened abortion, foetal developments, TBA
KABBA, Elizabeth	FEMALE	Convulsion, fibroid, headache, impotence (okobo), shocks reproduction (PPA)
SAM, Fayah	MALE	Back ache (lumbago)
SESAY, Mamie	FEMALE	TBA, wet dreams (threatened abortion), difficulty in delivery, malaria
MANSARAY, Foday	MALE	General herbalist
JOHNNY, Hawa	FEMALE	Impotence (okobo)
VANDI, Gbessay	FEMALE	Fibroid, kyphosis (humpback), epileptic fits, paralysis.
MORAY, Massa	FEMALE	Bone specialist
MORAY, Bockarie		Bone specialist

MAKAVORAY, Patmata		General herbalist
COLE, Christian	FEMALE	Bleeding
AMOIH, Elizabeth	FEMALE	Severe headache, pile, sinusitis
KAMARA, Salifu	MALE	Split head, sinusitis, severe wounds, bone fractures
BUNDU, Zainab	FEMALE	Eye complication, Okobo (impotence), paralysis
MALER-SESAY, Joseph	MALE	Syphilis, alay (skin problem), measles
CONTEH, Brima	MALE	Malaria, stomach pains
SESAY, Sorie	MALE	Barrenness, chronic malaria, sinusitis, piles, dry dysentery
SESAY, Balley	FEMALE	Cholera, vomiting, frequent stool, malaria, side pains, general pains.
BANGURA, Binluinga	MALE	Eye problems, snake bites, bleeding
JOHNSON, Esther	FEMALE	High fever, frequent stool
COLE, Ketura	FEMALE	Stomach pains, frequent stool
BROWN, Jesseka	FEMALE	Malaria, piles, headache
BANGURA, Alpha	MALE	Dysentery, malaria, stomach pains
SESAY, Siah	FEMALE	TBA
CONTEH, Mordiboh	MALE	Witch craft (evil spirits), barrenness, craziness, chronic sores
KARGBO, Andrew Yamba	MALE	Okobo (impotency), swollen stomach, witch craft, fanga (witch gun), craziness, menstrual troubles.

APPENDIX 10

SLENTHA Meetings Attended

Executive	General	Other
7 Jan 94	11 Jan	28 Feb Symposium
22 Mar	25 Jan	23 April: Songo visit
30 May	8 Feb	13 May: Songo visit
6 Jun	24 Mar	15 July Symposium
4 July	5 April	
	12 April	
	19 April	
	26 April	
	3 May	
	10 May	
	24 May	
	7 June	
	14 June	
	28 June	
	12 July	

APPENDIX 11

Cost of Treatment Tables (in leones: 410 leones = $1 Cdn.)

File Code	Pretreatment Costs	Traditional Healing	Programme Treatment	Total
1 Bo	30,000[1]	Y	10,000[2]	40,000
2	40,000	Y	14,200	54,200
3	24,000	Y	21,400	45,400
4	8,900	N	9,000	17,900
5	U[3]	Y	12,000	12,000
6	8,500	Y	10,500	18,500
7	2,500	Y	11,000	13,500
8	U	N	15,500	15,500
9	6,000+U	N	15,000	21,000
10	39,000	N	17,500	56,500
11	38,000+U	Y	24,000	62,000
12	200	Y	B[4]	200
13	400+U	Y	10,000	10,400
14	U	Y	10,000	10,000
15	0	N	B	0
16	0	N	B	0
17	U	N	13,600	13,600
18	U	N	10,000	10,000
19	U	N	0[5]	0
21	U	Y	11,000	11,000
Total	197,500	Yes-12; No-9	25,100	422,600

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[1] All costs in pretreatment phase including THPs.

[2] Transportation to programme centre, admission fee, extra drugs, pocket money, extra food, rent, tips paid to staff--all costs related to the treatment situation.

[3] U = Unknown: Some patients were unable to recall, or relatives had paid the costs on their behalf.

[4] B = Benefit: Covered by medical benefit package or nongovernmental organisation (NGO).

[5] This patient was not charged a fee because she was displaced. This was the only instance--all other displaced patients paid various fees.

File Code	Pretreatment Costs	Traditional Healing	Programme Treatment	Total
1 Lunsar	50,000	N	6,300	56,300
2	0	Y	3,300	3,300
3	9,300+U	N	2,300	11,600
4	14,000	Y	10,300	24,300
5	3,500	Y	300	3,800
6	600	Y	300	900
7	200,000	Y	5,300	205,300
8	7,000	Y	300	7,300
9	U	Y	300	300
10	2,000	Y	300	2,300
11	159,000	Y	300	159,300
12	117,000	Y	1,200	118,200
13	26,800+U	Y	300	27,100
14	14,400	N	10,300	24,700
15	U	Y	8,300	8,300
16	13,000	N	10,300	23,300
17	0	Y	24,300	24,300
18	U	Y	3,300	3,300
19	U	N	5,300	5,300
20	2,500	N	300	2,800
21	U	y	300	300
22	8,000	Y	300	8,300
23	20,000	Y	5,300	25,300
24	4,000	Y	10,300	14,300
25	U	Y	24,000	24,000
26	4,000+U	Y	300	4,300
Total	655,100	Yes-20; No-6	133,400	788,500

File Code	Pretreatment Costs	Traditional Healing	Programme Treatment	Total
1 Lakka	U	N	15,000	15,000
2	U	Y	0	0
3	3,000+U	Y	0	3,000
4	U	N	0	0
5	0	Y	3,500[6]	3,500
1 Makeni	14,000	Y	5,000	19,000
2	2,500	Y	5,000	7,500
3	0	N	5,000	5,000
1 Moyamba	6,200	Y	10,000	16,200
2	700	Y	6,500+U	7,200
3	3,000	Y	0	3,000
4	4,400	Y	19,000	23,400
5	500	N	10,000	10,500
6	2,600	Y	12,000	14,600
1Freetown	13,000	N	4,000	17,000
2	U	N	0	0
3	18,000	N	8,000	26,000
4	35,000	N	16,000	46,000
5	20,500	N	13,000	33,500
6	3,000	N	150 B	3,150
7	0	N	0 B	0
8	13,200	N	19,500	32,700
9	0	N	0 B	0
10	96,000	Y	32,500	128,500
11	33,500	Y	5,000	38,500
12	35,000	Y	25,000	60,000
Totals	304,100	Yes-13; No-13	214,500	518,250

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[6] This patient was unhappy with the side effects of the TB programme injections, so stopped taking them and sought the parallel services of a THP while still in hospital. The side effects subsided.

NANCY L. GIBSON

Currently President of Paradigm Consultants, an engineering and management consulting firm specialising in project management in the fields of health care delivery; relief and aid; planning and logistics for major operations; staff training and development.

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EDUCATION

1995 Ph.D. (in progress) University of Alberta (Medical Anthro.)

1985 M.A. University of Alberta (Political Anthropology)

1982 B.A. (with distinction) University of Alberta

1965 Post-Graduate Diploma in Teaching and Supervision, McGill University

1963 Post-graduate diploma in Neurological Nursing, Montreal Neurological Hospital

1962 R.N. Montreal General Hospital

ACADEMIC AWARDS

Killam Doctoral Fellowship 1994-96
Social Sciences and Humanities Research Council (SSHRC) Research Fellowship 1994-96
Andrew Stewart Award for outstanding PhD research 1994
Province of Alberta Graduate Fellowship 1992-93
University of Alberta PhD Scholarship for 1992-93; renewed for 1993-94

LANGUAGES: English, French, Spanish, some Krio